ANDREA UBHI
YORK

REFERRAL FORM FOR ENDODONTICS

To: Dr. Mahesh Vasireddy
23 Stonegate
York
YO1 8AW

or send by email to:
info@andreaubhi.com
fax to: 01904 613241
tel: 01904 639667

Date of referral:

Patient name:

Address:

Date of birth:

Home Tel:

Mobile:

Reason for referral:

Please indicate specific patient concerns if appropriate.

Referring dentist's details:

Name:

Address:

Phone number:

Fax or email:

Please enclose relevant radiographs, if available. These will be returned to you at the end of the treatment.

Relevant Medical History: