ULTRASOUND DOCTOR REFERRAL FORM

Please fax or scan completed form to: **778-508-7645**
or **info@mintintegrative.com**

Patient Name: _____

DOB: _____ Phone number: _____

Referring Physician: _____

Clinic Name/Address: _____

Clinic Phone: _____ Clinic Fax: _____

Clinic Email: _____

Brief medical history and reason for ultrasound referral:

_____

_____

_____

Are you including any previous imaging or reports? Yes ☐ No ☐

Reasons for ultrasound referral:

IUD placement check ☐
Endometrial lining measurement ☐
Antral follicle count ☐

Early pregnancy assessment ☐
Pelvic scan ☐

NOTE: Please ensure that your patient is aware that Mint does not provide diagnostic ultrasounds. The service provided is a point of care ultrasound, intended for informational purposes only, and no report will be provided. All ultrasound imaging is performed by naturopathic physicians.

☐ I have informed my patient about the intended use of point of care ultrasound (please check box)

Patients are required to have a 15-minute screening phone call with a physician prior to their ultrasound appointment. Please see fees below:

Fees*:
Ultrasound Phone Consult (15 min).....$75
Ultrasound Scan $120

Physician Signature: _____

Date: _____

Mint Integrative Health
Unit 485 - 1541 W Broadway
Vancouver, BC V6A 1E7

mintintegrative.com
info@mintintegrative.com

*Fees are as of December 2025 and may change at any time