

FORM A: REQUISITION FOR HOME SLEEP APNEA TEST (HSAT) (without Sleep Disorder Physician consultation)

ΡΔΤ	IENT INFORMATION (*denot	Ης ΔΤ ΕΔ	HSAT FACILITY INFORMATION				
Last Name* First Name* PHN*				Facility Name			
	This traine						
Date of Birth* (YYYY / MM / DD)	Gender	Preferred Language	Address				
	Gender		Address				
Primary Contact Number* Secondary Contact Number Email		Email					
				Address			Phone
Safety Critical Occupation* – if Ye	es, provide detail in Patient History						
Yes ONo (e.g. truck, taxi, bus drivers; airline/marine pilots; emergency personel; constructution workers; etc.)			REFERRING PRACTITIONER				
Patient History and Comorbid Conditions - please note if this is a follow-up HSAT study			Name*				
			MSP Number*				
					Clinic Name		
			Street Address STAMP				
						Phone	Fax
Allergies and Medications			Primary Care Provider*				
			Same as Referri	○ Same as Referring Practioner ○ None			
			Copy to (full name ar	d Speciality or MSP Number)			
DI	AGNOSTIC/REFERRAL DECIS	ION PATHWAY	DECISI	ON AND SIGNATURE			
Step 1: Determine if patient is at increased risk of moderate-to-severe Obstructive Sleep Apnea (OSA).			*Patient eligible for HSAT?				
		by the presence of excessive daytime	⊖ Yes	○ No			
	ue and at least two of the follow	ving three criteria:	. If Ves. forwa	rd requisition directly to			
	 Witnessed apneas or gasping or choking Habitual loud snoring Diagnosed hypertension 		 If Yes, forward requisition directly to an accredited HSAT facility (see list of Accredited HSAT Facilities at <u>https://www. cpsbc.ca/files/pdf/DAP-Accredited-Facilities-</u> 				
🗌 🗌 Diagnosed h							
Is patient at increased risk of moderate-to-severe OSA?		HSAT.pdf.)					
 If Yes, patient requires a diagnostic test. 			 If No, patient should be referred for a sleep 				
	If No and the patient is symptomatic, they may have another sleep disorder and should		disorder consultation (FORM B - HLTH 1945).				
	a sleep disorder consultation (FO						
Stan 2. Determine diagnes	tic tact. A patient with an increase	ad rick of moderate to covere OCA		ocal HSAT does not rule out OSA.			
Step 2: Determine diagnostic test. A patient with an increased risk of moderate-to-severe OSA should be sent for a Home Sleep Apnea Test (HSAT), unless one or more of the following			(FORM B - HLTH 194	Consider referral to a sleep disorders physician			
	eria apply (any one item preclude						
		chronic insomnia, sleep walking/talking).					
\square Risk of hypoventilation (e.g. neuromuscular disease, BMI ≥ 40 kg/m ²).		Referring Practitioner	Signature				
 Chronic/regular opiate medication use. 							
Significant cardiopulmonary disease (e.g. history of stroke, heart failure, moderate-to-severe lung disease).							
	-						
$\Box Previous negative or equivocal HSAT.$							
 Children < 16 years old. Inability to complete necessary steps for self-administered HSAT (e.g. cognitive, physical, or other barriers). 							
If sleep study is for treatment follow-up (e.g. weight loss, oral appliance, or surgery) HSAT is appropriate, unless one or more of the exclusion criteria detailed above applies.			Date Signed (YYYY / I	(טט / אוויו)			

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts.