BRITISH COLUMBIA | Ministry of Health

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

PATIENT INFORMATION (*denotes required field)

Last Name*	First Name*	PHN*

Date of Birth* (YYYY / MM / DD)	Gender	Preferred Language

Primary Contact Number*	Secondary Contact Number	Email

Address

Safety Critical Occupation* – *if Yes, provide detail in Patient History*

◯ Yes ◯ No (e.g. truck, taxi, bus drivers; airline/marine pilots; emergency personel; constructution workers; etc.)

Patient History and Comorbid Conditions - *please note if this is a follow-up HSAT study*

Allergies and Medications

HSAT FACILITY INFORMATION

Facility Name
MedPro Respiratory Care

Address
BC Centralized Scheduling

Email
HSAT@medprorespiratory.com

Phone	Fax
604-526-0208	604-521-9286

REFERRING PRACTITIONER

Name*

MSP Number*

Clinic Name

Street Address STAMP

Phone Fax

Primary Care Provider*

◯ Same as Referring Practioner ◯ None

Copy to (full name and Speciality or MSP Number)

DIAGNOSTIC/REFERRAL DECISION PATHWAY

Step 1: Determine if patient is at **increased risk of moderate-to-severe Obstructive Sleep Apnea (OSA).**

Increased risk of moderate-to-severe OSA is indicated by **the presence of excessive daytime sleepiness or fatigue and at least two of the following three criteria:**

- ☐ Witnessed apneas or gasping or choking
- ☐ Habitual loud snoring
- ☐ Diagnosed hypertension

Is patient at increased risk of moderate-to-severe OSA?

- If Yes, patient ***requires a diagnostic test***.
- If No and the patient is symptomatic, they may have another sleep disorder and should be referred for a sleep disorder consultation (FORM B - HLTH 1945).

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 HSAT exclusion criteria apply*** (any one item precludes HSAT):

- ☐ Concern for non-respiratory sleep disorder (e.g. chronic insomnia, sleep walking/talking).
- ☐ Risk of hypoventilation (e.g. neuromuscular disease, BMI ≥ 40 kg/m^2).
- ☐ Chronic/regular opiate medication use.
- ☐ Significant cardiopulmonary disease (e.g. history of stroke, heart failure, moderate-to-severe lung disease).
- ☐ 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.

DECISION AND SIGNATURE

***Patient eligible for HSAT?**

◯ Yes ◯ No

- If Yes, forward requisition directly to an **accredited HSAT facility** (see list of Accredited HSAT Facilities at https://www.cpsbc.ca/files/pdf/DAP-Accredited-Facilities-HSAT.pdf.)
- If No, patient should be referred for a sleep disorder consultation (FORM B - HLTH 1945).

A negative or equivocal HSAT does not rule out OSA. Consider referral to a sleep disorders physician (FORM B - HLTH 1945).

Referring Practitioner Signature

Date Signed (YYYY / MM / DD)

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.

Save Print Clear Form