

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 <input type="radio"/> Yes <input type="radio"/> No (e.g. truck, taxi, bus drivers; airline/marine pilots; emergency personnel; construction 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 Respiratory Homecare Solutions	
Address	
Email serviceforlife@rhscanada.com	
Phone 1-800-839-9046	Fax 1-855-884-7884

REFERRING PRACTITIONER	
Name*	
MSP Number*	
Clinic Name	
Street Address	STAMP
Phone	Fax
Primary Care Provider* <input type="radio"/> Same as Referring Practitioner <input type="radio"/> None	
Copy to (full name and Speciality or MSP Number)	

DIAGNOSTIC/REFERRAL DECISION PATHWAY
<p>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:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Witnessed apneas or gasping or choking <input type="checkbox"/> Habitual loud snoring <input type="checkbox"/> Diagnosed hypertension <p>Is patient at increased risk of moderate-to-severe OSA?</p> <ul style="list-style-type: none"> • 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). <p>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):</p> <ul style="list-style-type: none"> <input type="checkbox"/> Concern for non-respiratory sleep disorder (e.g. chronic insomnia, sleep walking/talking). <input type="checkbox"/> Risk of hypoventilation (e.g. neuromuscular disease, BMI ≥ 40 kg/m²). <input type="checkbox"/> Chronic/regular opiate medication use. <input type="checkbox"/> Significant cardiopulmonary disease (e.g. history of stroke, heart failure, moderate-to-severe lung disease). <input type="checkbox"/> Previous negative or equivocal HSAT. <input type="checkbox"/> Children < 16 years old. <input type="checkbox"/> Inability to complete necessary steps for self-administered HSAT (e.g. cognitive, physical, or other barriers). <hr/> <p><i>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.</i></p>

DECISION AND SIGNATURE
<p>*Patient eligible for HSAT?</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <ul style="list-style-type: none"> • 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). <p><i>A negative or equivocal HSAT does not rule out OSA. Consider referral to a sleep disorders physician (FORM B - HLTH 1945).</i></p>
Referring Practitioner Signature
Date Signed (YYYY / MM / DD)