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
Respiratory Homecare Solutions

Address

Email
serviceforlife@rhscanada.com

| Phone | Fax |
|---|---|
| 1-800-839-9046 | 1 866-812-0202 |

### 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)

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