

**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 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	
Address	
Email	
Phone	Fax

REFERRING PRACTITIONER	
Name*	
MSP Number*	
Clinic Name	
Street Address	STAMP
Phone	Fax
Primary Care Provider*	
☐ Same as Referring Practitioner ☐ 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/m²). ☐ 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). <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>

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)