

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 Independent Respiratory Services Inc.	
Address	
Email referrals@irscanada.ca	
Phone 1 877-965-6204	Fax 1 866-812-0202

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><b>Step 1:</b> Determine if patient is at <b>increased risk of moderate-to-severe Obstructive Sleep Apnea (OSA)</b>.            Increased risk of moderate-to-severe OSA is indicated by <b>the presence of excessive daytime sleepiness or fatigue and at least two of the following three criteria:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Witnessed apneas or gasping or choking</li> <li><input type="checkbox"/> Habitual loud snoring</li> <li><input type="checkbox"/> Diagnosed hypertension</li> </ul> <p><b>Is patient at increased risk of moderate-to-severe OSA?</b></p> <ul style="list-style-type: none"> <li>• If Yes, patient <b>requires a diagnostic test</b>.</li> <li>• 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).</li> </ul> <p><b>Step 2:</b> Determine diagnostic test. A patient with an increased risk of moderate-to-severe OSA <b>should be sent for a Home Sleep Apnea Test (HSAT), unless one or more of the following HSAT exclusion criteria apply</b> (any one item precludes HSAT):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Concern for non-respiratory sleep disorder (e.g. chronic insomnia, sleep walking/talking).</li> <li><input type="checkbox"/> Risk of hypoventilation (e.g. neuromuscular disease, BMI ≥ 40 kg/m<sup>2</sup>).</li> <li><input type="checkbox"/> Chronic/regular opiate medication use.</li> <li><input type="checkbox"/> Significant cardiopulmonary disease (e.g. history of stroke, heart failure, moderate-to-severe lung disease).</li> <li><input type="checkbox"/> Previous negative or equivocal HSAT.</li> <li><input type="checkbox"/> Children &lt; 16 years old.</li> <li><input type="checkbox"/> Inability to complete necessary steps for self-administered HSAT (e.g. cognitive, physical, or other barriers).</li> </ul> <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><b>*Patient eligible for HSAT?</b></p> <p><input type="radio"/> Yes   <input type="radio"/> No</p> <ul style="list-style-type: none"> <li>• If Yes, forward requisition directly to an <b>accredited HSAT facility</b> (see list of Accredited HSAT Facilities at <a href="https://www.cpsbc.ca/files/pdf/DAP-Accredited-Facilities-HSAT.pdf">https://www.cpsbc.ca/files/pdf/DAP-Accredited-Facilities-HSAT.pdf</a>).</li> <li>• If No, patient should be referred for a sleep disorder consultation (FORM B - HLTH 1945).</li> </ul> <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)