

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

PATIENT INFORMATION (*denotes required field)				HSAT FA	HSAT FACILITY INFORMATION	
Last Name* PHN*				Facility Name		
Date of Birth* (YYYY / MM / DD)	Gender	Preferre	l d Language	Address		
Primary Contact Number*	Secondary Contact Number Email		Email			
Address				Phone	Fax	
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.)				REFER	RING PRACTITIONER	
Patient History and Comorbid Conditions - please note if this is a follow-up HSAT study				Name*		
				MSP Number*		
				Clinic Name		
				Street Address	STAMP	
				Phone	Fax	
				1 Holle	T GA	
				Primary Care Provid	er*	
Allergies and Medications				· · ·	Same as Referring Practioner None	
					g · ············	
				Convito (full name a	and Speciality or MSP Number)	
				Copy to (full flatfle a	nd speciality of MSF Number/	
DIA	GNOSTIC/REFERRAL DECI	SION DAT	HWΔV	DECIS	ION AND SIGNATURE	
l .			Obstructive Sleep Apnea (OSA).	*Patient eligibl	e for HSAT?	
	lerate-to-severe OSA is indicate			○ Yes	○ No	
sleepiness or fatigue and at least two of the following three criteria:			• If Yes, forwa	ard requisition directly to		
☐ Witnessed apneas or gasping or choking				ted HSAT facility (see list of		
	☐ Habitual loud snoring				HSAT Facilities at https://www.	
	☐ Diagnosed hypertension				les/pdf/DAP-Accredited-Facilities-	
<u>-</u>	ed risk of moderate-to-severe	e OSA?		HSAT.pdf.)		
 If Yes, patient requires a diagnostic test. 				nt should be referred for a sleep		
 If No and the patient is symptomatic, they may have another sleep be referred for a sleep disorder consultation (FORM B - HLTH 1945) 			disorder co	disorder consultation (FORM B - HLTH 1945).		
	•		•		ivocal HSAT does not rule out OSA.	
	c test. A patient with an increase Home Sleep Apnea Test (HSA)			(FORM B - HLTH 19	to a sleep disorders physician 945)	
	ria apply (any one item preclud		one or more or the ronowing	(10111113 11211113	. 15).	
	n-respiratory sleep disorder (e.g		somnia, sleep walking/talking).			
\Box Risk of hypoventilation (e.g. neuromuscular disease, BMI ≥ 40 kg/m²).				Referring Practition	er Signature	
	ar opiate medication use.	,	3			
☐ Significant cardiopulmonary disease (e.g. history of stroke, heart failure,						
	evere lung disease).	,	,			
☐ Previous negative or equivocal HSAT.						
☐ Children < 16 years old.						
☐ Inability to cor	nplete necessary steps for self-	administer	ed HSAT (e.g. cognitive,			
physical, or otl						
	treatment follow-up (e.g. weight s one or more of the exclusion cri			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.

HLTH 1944 2021/06/22