Initial Home Oxygen Risk Mitigation Form (IHORM) and Home Oxygen Consent Form (HOCF) for new patients only.

BOTH FORMS MUST BE COMPLETED AND SIGNED BEFORE OXYGEN CAN BE INSTALLED.

DO NOT SEND FORMS TO SUPPLIER FORMS WILL BE PLACED IN PATIENT NOTES

THERE ARE CONFIRMATION BOXES ON THE HOME OXYGEN ORDER FORMS.

Oxygen can pose a risk of harm to the user and others in the event of fires, falls and inability to use complex equipment. The initial identification and onward communication of these risks is the responsibility of the health care professional ordering the oxygen and remains so until that prescription ceases or is superseded. The table below reflects risk factors that are based on evidence of real life serious and untoward incidents, 90% of which are smoking and e-cigarette/charger related.

The Initial Home Oxygen Risk Mitigation (IHORM) is to be completed in conjunction with the Home Oxygen Consent Form (HOCF) prior to oxygen being ordered from the oxygen supplier via the Home Oxygen Order Form (HOOF). **It is the responsibility of the registered health care professional who is gaining consent to complete and add the IHORM with the HOOF and HOCF to the patient's notes. If all documents are not confirmed as being completed in full the Home Oxygen Order cannot be fulfilled.**

If the risks identified on the IHORM indicate significant levels of risk the patient should be discussed directly with the local Home Oxygen Service or Clinical Oxygen Lead for a full risk assessment prior to oxygen being ordered as recommended in the National Safety Toolkit and the British Thoracic Home Oxygen Guidelines June 2015**. Regardless of risk or diagnosis all adult patients should be referred the Home Oxygen Service for the team to determine next steps if deemed relevant.**

If any responses below fall within a shaded box, please refer to the Required Action column and supporting notes.

All actions should be explained to the patient and why they are being taken in line with service contracts. Ensure that both verbal and written information has been given to the patient or their representative.

Patient Name		DOB		
Address		Oxygen requested?		**Yes - Sending HOOF** **No - Risk is too high**
Recorded at	please circle Hospital Clinic / Home / other location	NHS No		
Risk Level	**Risks**	**No**	**Yes**	**Required Action**
HIGH	Does the patient smoke cigarettes / e-cigarettes?			If a High Risk is identified (shaded box), **It is highly recommended that oxygen is not requested without** referral to Home Oxygen Service **or** Respiratory Specialist **or** support services e.g. falls team, stop smoking service,
	Have they smoked in the last 6 months? Quit date.....			
	Does anyone else smoke at the patients premises?			
	A recent history of drug or alcohol dependency?			
	Patient reported they have had a fall in the last 3 months?			
	Have they had previous burns or fires in the home?			
	Does the person have identified mental capacity issues?			
MODERATE	Can the patient leave their property un-aided?			If 3 or more risks are identified (shaded box), **It is highly recommended that oxygen is not requested without** referral to Home Oxygen Service **or** Respiratory Specialist **or** support services e.g. stop smoking service,
	Is the patient or any dependents/ in the property vulnerable? E.G. disabilities/ children			
	Do they live in a home that is joined to another?			
	Patient reports they have working smoke alarms at home? (if unknown please state no)			
	Do they live in a multiple occupancy premises (Bedsit/flat)			

Mitigation actions taken e.g. contacted falls team Referred to Fire and Rescue

Declaration I confirm that I am the healthcare professional responsible for the care of this patient. I have discussed the risks listed on this form with the patient/carer/ guardian (delete as necessary) and from the responses given Oxygen can/cannot (delete as necessary) be requested at this time.

Clinicians Signature		Profession	
Print Name		HOS team	Yes / No
Contact No.		Date	
Lead Consultant is	(Hospital Discharge only)		

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Patient agreement to sharing information

Form issued by:			
Unit/Surgery		**Address**	
Contact name			
Tel no.			
Email		**Postcode**	

Patient			
Name		**Address**	
D.O.B.			
NHS number			
Tel/mobile no.		**Postcode**	
E-mail		(only include if the patient agrees to email contact)	

My doctor or a member of my care team has explained the arrangements for supplying Oxygen at my premises, that my personal information will be managed and shared in line with the Data Protection Act 1998, Human Rights Act 1998, and common law duty of confidentiality and I understand these arrangements, such that:

1. Information about my condition/condition of the patient named above* will be provided to the Home Oxygen Service (HOS) Supplier to enable them to deliver the Oxygen treatment as per the Home Oxygen Order Form (HOOF).

2. The HOS Supplier will be granted reasonable access to my premises, so that the Oxygen equipment can be installed, serviced, refilled and removed (as appropriate).

3. Information will be exchanged between my hospital care team, my doctor, the home care team and other teams (e.g. NHS administration) as necessary related to the provision, usage, and review, of my Oxygen treatment, and safety.

4. Information will also be shared with the local Fire Rescue Services team to allow them to offer safety advice at my premises and where appropriate install/deliver suitable equipment for safety.

5. Information will also be shared with my electricity supplier/distributer where electrical devices have been installed.

6. From time to time, I may be contacted to participate in a patient satisfaction survey/audit. (delete *should you wish not to participate)*

7. I understand that I may withdraw my consent at any time (at which point my HOS equipment will be removed).

* Delete as applicable

Patient's signature		**Date**	

(see note 4 where signed and witnessed on patient's behalf)

I confirm that I have responsibility for the above-named patient.

Carer's signature		**Name**	
Relationship to patient		**Date**	

I confirm that I am the healthcare professional responsible for the care of this patient and I have completed this form on his/her behalf as s/he is unable to provide/withhold consent. The patient has been given a copy of this form.

Clinician's signature		**Date**	
Name			