Home Oxygen Order Form (HOOF)

NHS

Part A (Before Oxygen Assessment – Non-Specialist or Temporary Order)

All fields marked with a '*' are mandatory and the HOOF will be rejected if not completed

This part completed form is only to be used for O2 therapy for CH sufferers

1. Patient Details

1.1 NHS Number*		1.7 Permanent address*	1.9 Tel no.
1.2 Title			1.10 Mobile no.
1.3 Surname*			**2. Carer Details (if applicable)**
1.4 First name*			2.1 Name
1.5 DoB*			2.2 Tel no.
1.6 Gender	☐ Male ☐ Female	1.8 Postcode*	2.3 Mobile no.

3. Clinical Details

3.1 Clinical Code*	18	
3.2 Patient on NIV/CPAP	☐ Yes	☐ No
3.3 Paediatric Order	☐ Yes	☐ No

4. Patient's Registered GP Information

4.1 Main Practice name:*	
4.2 Practice address:	
4.3 Postcode*	4.4 Telephone no

5. Assessment Service (Hospital or Clinical Service)

5.1 Hospital or Clinic Name:	
5.2 Address	
5.3 Postcode:	5.4 Tel no:

6. Ward Details (if applicable)

6.1 Name:
6.2 Tel no.:
6.3 Discharge date: / /

7. Order* / 8. Equipment* / 9. Consumables*

8. Equipment*: For more than 2 hours/day it is advisable to select a static concentrator

9. Consumables*: (select one for each equipment type)

Litres / Min	Hours / Day	Type	Quantity	Nasal Canulae	Mask % and Type
		8.1 Static Concentrator Back up static cylinder(s) will be supplied as appropriate			
15 LTRS	Up to 4 hrs	8.2 Static Cylinder(s) A single cylinder will last for approximately 8hrs at 4l/min		N/A	100% non-rebreather

10. Delivery Details*

10.1 Standard (3 Business Days) ☐	10.2 Next (Calendar) Day ☐	10.3 Urgent (4 Hours) ☐

11. Additional Patient Information

12. Clinical Contact (if applicable)

12.1 Name:	
12.2 Tel no.	12.3 Mobile no.

13. Declaration*

I declare that I am the registered healthcare professional responsible for the information provided, the information given on this form for NHS treatment is correct and complete. I understand that if I knowingly provide false information, I may be liable to prosecution or civil proceedings.

I have completed/ or confirm there is a previously signed copy of the Home Oxygen consent form **HOCF** ☐ **AND**
The Initial Home Oxygen Risk Mitigation Form **HORM** ☐

Name:	Profession:	
Signature:	Date:	Referred for assessment: ☐ Yes ☐ No
Fax back no. or NHS email address for confirmation / corrections:		

14. Primary Clinical Code

CODE	Condition	CODE	Condition
1	Chronic obstructive pulmonary disease (COPD)	11	Neuromuscular disease
2	Pulmonary vascular disease	12	Neurodisability
3	Severe chronic asthma	13	Obstructive sleep apnoea syndrome
4	Interstitial lung disease	14	Chronic heart failure
5	Cystic fibrosis	15	Paediatric interstitial lung disease
6	Bronchiectasis (not cystic fibrosis)	16	Chronic neonatal lung disease
7	Pulmonary malignancy	17	Paediatric cardiac disease
8	Palliative care	18	Cluster headache
9	Non-pulmonary palliative care	19	Other primary respiratory disorder
10	Chest wall disease	20	Other If no other category applicable