Home Oxygen Order Form (HOOF)

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

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*

For more than 2 hours/day it is advisable to select a static concentrator

(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 2 hrs	8.2 Static Cylinder(s) A single cylinder will last for approximately 8hrs at 4l/min	2	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

CLUSTER HEADACHE PT PLEASE SUPPLY B10P SCHRADER VALVE CYLINDERS AND DEMAND VALVE

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