

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	<input type="checkbox"/> Male <input type="checkbox"/> Female	1.8 Postcode*	2.3 Mobile no.	

3. Clinical Details**4. Patient's Registered GP Information**

3.1 Clinical Code(s)		4.1 Main Practice name:*
3.2 Patient on NIV/CPAP	<input type="checkbox"/> Yes <input type="checkbox"/> No	4.2 Practice address:
3.3 Paediatric Order	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		4.3 Postcode*
		4.4 Telephone no.

5. Assessment Service (Hospital or Clinical Service)**6. Ward Details (if applicable)**

5.1 Hospital or Clinic Name:		6.1 Name:
5.2 Address		6.2 Tel no.:
		6.3 Discharge date: / /
5.3 Postcode:	5.4 Tel no:	

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

10. Delivery Details*

10.1 Standard (3 Business Days)	<input type="checkbox"/>	10.2 Next (Calendar) Day	<input type="checkbox"/>	10.3 Urgent (4 Hours)	<input type="checkbox"/>
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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 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 confirm that I am the registered healthcare professional responsible for the information provided. I also confirm that the patient has read and signed the Home Oxygen Consent Form.

Name:		Profession:	
Signature:		Date:	Referred for assessment: <input type="checkbox"/> Yes <input type="checkbox"/> No

Fax back no. or NHS email address for confirmation / corrections:

14. Clinical Code

CODE	Condition	CODE	Condition
1	Chronic obstructive pulmonary disease (COPD)	12	Neurodisability
2	Pulmonary vascular disease	13	Obstructive sleep apnoea syndrome
3	Severe chronic asthma	14	Chronic heart failure
4	Interstitial lung disease	15	Paediatric interstitial lung disease
5	Cystic fibrosis	16	Chronic neonatal lung disease
6	Bronchiectasis (not cystic fibrosis)	17	Paediatric cardiac disease
7	Pulmonary malignancy	18	Cluster headache
8	Palliative care	19	Other primary respiratory disorder
9	Non-pulmonary palliative care	20	Other
10	Chest wall disease	21	Not known
11	Neuromuscular disease		