INSTRUCTIONS ON HOW TO COMPLETE A HOOF FORM CORRECTLY

PLEASE FAX HOOF To:

: AIR LIQUIDE – 0870 8632111
: PATIENTS GP SURGERY
: OXYGEN ASSESSMENT - KGH 01536 491860 or NGH 01604 544317

Air Liquide will reject all HOOFs if the following key information is missing

BOXES 1 – 4
PLEASE COMPLETE ALL BOXES
Reject if missing

: Patient NHS number
:Surname
: First name
: Date of Birth
: Gender

: Full Address
: Postcode
: Tel Number

: Clinical Code
: GP Practice name
: GP full address
: GP postcode
: GP tel number

BOX 5
Complete the following information

: Hospital name,
: Full address Inc postcode
: Telephone number

BOX 7
COMPLETE THE BOX
Reject if missing

: Litres/Min
: Hours/Day

BOX 10
Reject if missing

:Tick the box which applies to patients discharge
TRY AND AVOID URGENT REQUESTS AS THE CHARGE IS HIGHER

BOX 13
PLEASE COMPLETE ALL THE BOXES
Reject if missing
: Name
: Signature
: Profession
: Date
: Referred for oxygen assessment

BOX 14
List of clinical codes, choose which code relates to the patient and enter in Box 3.1

BOX 6
Complete the following information

: Ward name,
: Ward telephone number
: Ward Discharge Date

BOXES 8 – 9
PLEASE COMPLETE ALL THE BOXES
Reject if missing

: Quantity required of Static concentrator or Static cylinder
: DO NOT ORDER BOTH
:Concentrator SHOULD ONLY BE ORDERED NO OTHER OXYGEN OTHER THAN LTOT SHOULD BE ORDERED DO NOT ORDER SHORT BURST

: Select if Nasal canulae or Mask %
If Canulae and Mask are required please request in Box 11

BOX 12
PLEASE COMPLETE ALL THE BOXES
: Contact name
: Contact telephone number

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

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			4. Patient's Registered GP Information	
3.1 Clinical Code(s)			4.1 Main Practice name:*	
3.2 Patient on NIV/CPAP	☐ Yes	☐ No	4.2 Practice address:	
3.3 Paediatric Order	☐ Yes	☐ 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* 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			
		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) ☐	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 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 ☐ Yes ☐ 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		