

## 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*					<b>2. Carer Details (if applicable)</b>
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*			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.:		
5.3 Postcode:			6.3 Discharge date: / /		
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"/>
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 <b>HOCF</b> <input type="checkbox"/> <b>AND</b>					
The Initial Home Oxygen Risk Mitigation Form <b>IHORM</b> <input type="checkbox"/>					
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. Primary Clinical Code					
CODE	Condition	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		