Home Oxygen Order Form (HOOF)

Read guidance notes before completing.

NHS

Before you start

Use this form as a healthcare professional ordering patient oxygen for a home setting.

Make sure you complete all sections accurately and legibly to avoid rejection. Mark (**X**) all options that apply (leave others blank). Include contact name and telephone number to resolve queries.

☒ **Completed the Home Oxygen Consent Form (HOCF)**

By law, patient's consent is needed to transfer personal information to supplier and for supply to begin.

If no consent, order will be rejected.

After completing this form

Keep copy in patient records.

GP: Fax to supplier and PCT/LHB.

Hospital or Clinic: Fax to supplier, patient's GP and PCT/LHB.

Supply problem: Refer patient to supplier helpline.

1 PATIENT'S DETAILS

1.1 **Title**

1.2 **Surname**

1.3 **First name**

1.4 **Gender** ☐ M ☐ F

1.5 **DOB**

1.6 **NHS no.**

1.7 **Permanent home address**

Postcode

1.8 **Tel no.**

1.9 **Mobile no.**

1.10 **Carer's name**

1.11 **Carer's tel no.**

1.12 **Carer's mob no.**

1.13 **Secondary supply address**

Holiday, school, respite, workplace etc

Make sure permanent address also completed

Postcode

1.14 **Contact name**

1.15 **Contact tel no.**

1.16 **Dates at address** (from and to)

Clinical details

1.17 **Clinical code** 20

1.18 ☐ Paediatric order

1.19 ☐ On NIV/CPAP

1.20 ☐ Tracheostomy

1.21 **Important details**

Add additional patient information helpful to supplier (disability, frail, language needs)

2 GP'S DETAILS

2.1 **Main practice name** (not branch)

2.2 **Practice address**

Postcode

2.3 **PPD practice code**

2.4 **Practice tel no.**

2.5 **Practice fax no.**

2.6 **PCT/LHB name** (for charging purposes)

3 CLINICAL CONTACT FOR QUERIES

3.1 **Contact name**

3.2 **Tel no.**

3.3 **Fax no.**

4 HOSPITAL OR COMMUNITY CLINIC DETAILS

4.1 **Name**

4.2 **Hospital or clinic address**

Postcode

4.3 **Tel no.**

4.4 **Fax no.**

For hospital discharge complete sections 4.5 – 4.8

4.5 **Patient hospital no.**

4.6 **Ward name**

4.7 **Ward tel no.**

4.8 **Date of discharge**

5 LONG-TERM OXYGEN THERAPY

5.1 **Litres/min**

5.2 **Hours/day**

5.3 **Services**

☐ Nasal cannulae

☐ Mask %

If unsure, contact supplier

☐ Interim supply pre-assessment

☐ Humidification

Not usually for flow rates below 4l/min

6 AMBULATORY SERVICE (PORTABLE)

Specialist assessment needed prior to ordering

6.1 **Litres/min** 15

6.2 **Hours/day** 1 or more hrs per day

6.3 **Services**

N ☐ Nasal cannulae

Y ☐ Mask % 100

If unsure, contact supplier

☐ Conserving device contra indicated

Y ☐ Lightweight equipment

Only where patient assessed

7 SHORT BURST OXYGEN THERAPY

7.1 **Litres/min** 15

7.2 **Mins/day** ☐ 15 ☐ 30 ☐ 60

☐ Up to 120 up to 4hrs Other (specify)

7.3 **Services**

N ☐ Nasal cannulae

Y ☐ Mask % 100

If unsure, contact supplier

☐ Interim supply pre-assessment

8 DELIVERY DETAILS

☐ Standard *(Within 3 working days)*

☐ Next day *(Clinical assessment services and hospital discharges only)*

☐ Urgent response *(4-hour delivery)*

Order only when clinically appropriate

9 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 also confirm that I am the registered healthcare professional responsible for the information provided.

Name

Profession

Signature

Date

Home Oxygen Order Form (HOOF)

Guidance notes. Please read before completing order.

Home Oxygen Consent Form (HOCF): Must be completed. Consent by patient is **not** consent to treatment but the transfer of patient personal information to the supplier to support service delivery, as required by the Data Protection Act 1998 and is essential when patient first receives home oxygen service. **Important: HOOF must be accurate and legible**.

1 PATIENT'S DETAILS

1.5 Date of birth will confirm if the order is paediatric.
1.10 Include carer's details, as appropriate.
1.13 Only complete this if delivery is to temporary address (eg holidays, respite care) or alternative address (eg school or workplace).
1.16 Insert dates for period that patient is away from permanent address and needs supply for these dates.
1.17 **Important:** Insert Clinical Code if known. Use correct code from list below.

01	Chronic obstructive pulmonary disease (COPD)	12	Paediatric interstitial lung disease
02	Pulmonary vascular disease	13	Chronic neonatal lung disease
03	Severe chronic asthma	14	Neuromuscular disease
04	Primary pulmonary hypertension	15	Paediatric cardiac disease
05	Interstitial lung disease	16	Neurodisability
06	Pulmonary malignancy	17	Chest wall disease
07	Cystic fibrosis	18	Other primary respiratory disorder
08	Palliative care	19	Obstructive sleep apnoea syndrome
09	Bronchiectasis (not cystic fibrosis)	20	Cluster headache
10	Non-pulmonary palliative care	21	Other
11	Chronic heart failure	22	Not known

1.21 **Important:** Provide any additional information helpful to the supplier (eg patient has disability/frail/language needs).

2 GP'S DETAILS

2.2 Must include main practice address, not branch address, for billing.
2.3 For GP practice order, add practice code.
2.5 Fax number is required for oxygen supplier to confirm receipt of order.
2.6 Add name of PCT/LHB to charge for service(s) ordered.

3 CLINICAL CONTACT FOR QUERIES

Include contact name, telephone and numbers for supplier to contact clinic for queries.

4 HOSPITAL OR COMMUNITY CLINIC DETAILS

4.5 **Important: For hospital discharge order, please confirm if supply is needed next day after discharge (Box 8).**

5 LONG-TERM OXYGEN THERAPY (LTOT)

Prescribe LTOT for patient needing oxygen **continuously** (usually at least 15 hours a day, including at night). **Assessment recommended before LTOT. Complete boxes 5 and 6 if order is paediatric. Important: LTOT order does not include equipment to support supply outside the home; if needed, also complete Box 6. Infants on LTOT will usually need ambulatory oxygen.**

5.1 **Important: Must insert correct flow rate in litres per minute.**
5.2 **Important: Must insert correct number of hours of use for every 24 hours.**
5.3 Please indicate if mask or cannulae required.
Masks: Supply will be at appropriate flow rate to % prescribed. If unsure, contact supplier.
Humidification not usually recommended for flow rates below 4 litres per minute.

6 AMBULATORY SERVICE (PORTABLE)

Assessment needed prior to ordering.
6.1 Flow rate may be same as LTOT but hours of use will be different.
6.3 Confirm supply of mask (%) or cannulae. If conserving device is requested, cannulae will be supplied**.**
If conserving device is contra-indicated, tick box.
Lightweight equipment: **Standard ambulatory equipment will be provided unless patient assessment states a specific need for lightweight equipment** The 'lightweight' option is indicated for patients who are mobile and need to leave the home on a regular basis but find that the weight of the standard ambulatory oxygen cylinder affects their breathing and/or mobility.

7 SHORT BURST OXYGEN THERAPY (SBOT)

Prescribe SBOT for patient needing oxygen intermittently for up to two hours in a day.
7.3 Confirm supply of mask (%) or cannulae.

8 DELIVERY DETAILS

Supplier	Tel	Fax	Service Regions
Air Products	0800 373 580	0800 214 709	North West, Yorks & Humberside, East Midlands, West Midlands, North London, Wales
Air Liquide	0500 823 773	0800 7814 610	South London, South Central, South East Coast
Air Liquide	0808 202 2229	0191 4974 340	North East, South West
BOC Healthcare	0800 136 603	0800 1699 989	East of England