

BOC HOOF help guide

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

NHS

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.:	
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
		8.1 Static Concentrator: Back up static cylinder(s) will be supplied as appropriate	Nasal Canulae
		8.2 Static Cylinder(s) A single cylinder will last for approximately 8hrs at 4l/min	Mask % and Type
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 HOCF <input type="checkbox"/> AND The Initial Home Oxygen Risk Mitigation Form IHORM <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. 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		

Must include NHS Number DOB and clinical code

Please provide the address of which you require the delivery to be made and a valid contact number

Must be a numerical value no greater than 24hpd. PRN not accepted. If adding ambulatory whole form must not exceed 24hpd

The form must contain GP information to ensure account is aligned to the correct CCG

If requesting portables a GP can only request 1hpd at the same flow rate as domiciliary prescription. Please use the static cylinder line and indicate that you need portables

Must be a % compatible with flow

Please tick if canulae is required. A consumable MUST be selected

There must be a name and signature from a qualified clinician

Important: both check boxes MUST be completed or the HOOF will be rejected.

A Fax number or NHS.net email address ensures you will receive a confirmation that your order is being processed

All prescriptions supersede the last so please ensure all details are added