Fill all fields to ensure FAX is not rejected by the oxygen supplier

Home Oxygen Order Form (HOOF)

Please read the accompanying guidance notes before completing this order form

NHS

1

Title:	Gender: M / F
Surname:	
First name:	
Date of Birth:	
Patient Tel. Number:	
Mobile Tel. No:	
Patient NHS No:	
Patient Hospital No:	

Is this a Paediatric order? Yes ☐ No ☑

Has Patient consent been obtained Yes ☑ No ☐

2

Patient's address (use label where available)

Post Code:

Is this the permanent home address? Yes ☑ No ☐

(if no please give more details in 6 to assist the oxygen supplier)

or **School / Work address give additional information in 13**

Carer's Name:

Carer Tel. Number:

3

Clinical contact for enquiries (GP practice or assessment team)

Name:

Tel. No: Fax:

E-mail:

4

Hospital address and Code:

Post Code:

Tel. No: Fax:

E-Mail:

PCT / LHB Name:

5 Patient's GPs practice (main branch) address:

6 If this is a **Holiday Order** give additional information in 13 below

7 LONG TERM OXYGEN THERAPY

Litres / minute:

Hours / day:

Nasal cannulae Yes ☐ No ☐

Mask (__ __ %)

Humidification Yes ☐ No ☑

8 AMBULATORY

Litres / minute:

Hours / day:

Initial two month's supply Yes ☐ No ☐

Light weight option Yes ☐ No ☑

9 SHORT BURST OXYGEN

Litres / minute: –

Hours / day: < 2

Nasal cannulae Yes ☐ No ☑

Mask (24 %)

10 EMERGENCY ORDER

Duration of emergency order ____ days (max 3 days)

11 HOSPITAL DISCHARGE ORDER

Is next day response required Yes ☐ No ☐

Is this temporary prior to stable assessment for LTOT Yes ☐ No ☐

Ward tel. no.

Please complete boxes 7 or 9 for service required.

12 Date of planned assessment / order review date

13 Additional information for the home oxygen service supplier

14 Clinical information

Clinical code: __ __

On NIV Yes ☐ No ☑

On CPAP Yes ☐ No ☑

Conserving device contra indicated ☑

15 I confirm that I am a registered healthcare professional

Signature:	Date:	Pin:
Name (Print):	Position:	
E-mail:	Tel. No:	Fax No:

Original to oxygen supplier FAX Number..... Copies to: PCT / LHB, GP, Trust Clinical Lead for home oxygen, Patient's record. It is an offence to falsify the details on this form. The NHS Counter Fraud Service will pursue all sanctions, including appropriate legal action, against any persons committing fraud.

3 day emergency supply – remember to send a second replacement HOOF for on going need

Select disease/condition code from back of form and insert number

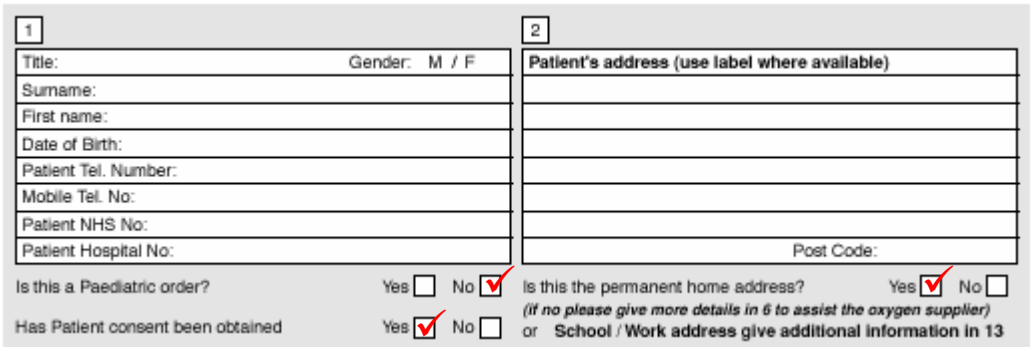
****IMPORTANT to tick**

This is your GMC or NMC number

FAX to

- **The oxygen supplier** (Supplier will send confirmation FAX)
- **PCT**
- **Keep copy in patient's records**

BOX by BOX how to complete the HOOF

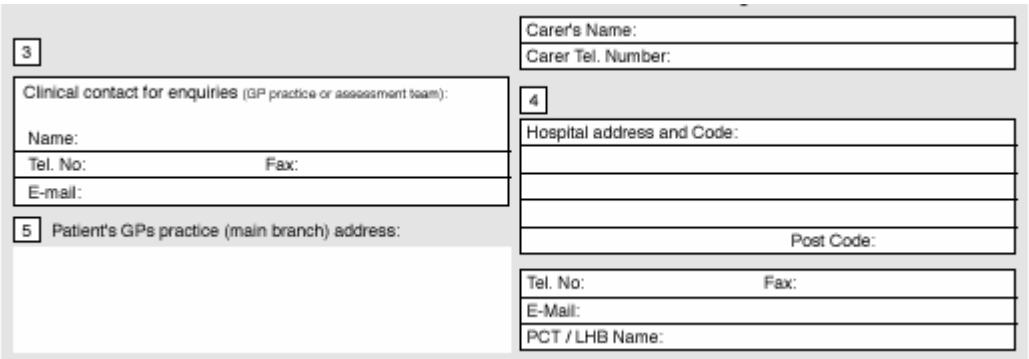


1		2	
Title:	Gender: M / F	**Patient's address (use label where available)**	
Surname:			
First name:			
Date of Birth:			
Patient Tel. Number:			
Mobile Tel. No:			
Patient NHS No:			
Patient Hospital No:			Post Code:

Is this a Paediatric order? Yes ☐ No ☑ Is this the permanent home address? Yes ☑ No ☐

Has Patient consent been obtained Yes ☑ No ☐ *(if no please give more details in 6 to assist the oxygen supplier)* or **School / Work address give additional information in 13**

Boxes 1 & 2 – straight forward patient details
Remember to tick if paediatric order
Remember to ensure written consent using HOCF and tick YES
Remember to tick home address – if not enter details in box 13



3		Carer's Name:
Clinical contact for enquiries (GP practice or assessment team):		Carer Tel. Number:
Name:		4
Tel. No:	Fax:	Hospital address and Code:
E-mail:		
5 Patient's GPs practice (main branch) address:		Post Code:
		Tel. No: Fax:
		E-Mail:
		PCT / LHB Name:

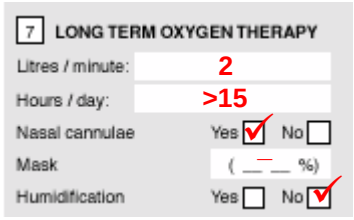
Boxes 3 & 4 – straight forward prescribers' details, GP, PCT & hospital info
Remember to give PCT name

6 If this is a **Holiday Order** give additional information in 13 below

Box 6 – if holiday order use box 13 to give details – include destination address, length of holiday and oxygen requirement – a separate HOOF is required for this

Boxes 7, 8 & 9 – are request specific oxygen requirements

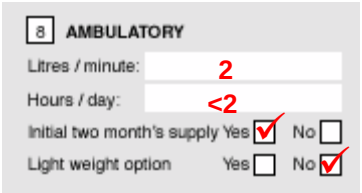
e.g.



7 LONG TERM OXYGEN THERAPY	
Litres / minute:	2
Hours / day:	>15
Nasal cannulae	Yes ☑ No ☐
Mask	(__ __ %)
Humidification	Yes ☐ No ☑

Box 7 – This is for patients who require oxygen for a minimum of 15 hours per day. Data of existing concentrator users will already have been given to the oxygen supplier. Humidification is not normally Required on flow of <4L/min.

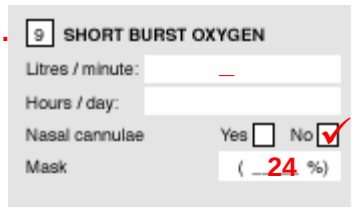
e.g.



8 AMBULATORY	
Litres / minute:	2
Hours / day:	<2
Initial two month's supply	Yes ☑ No ☐
Light weight option	Yes ☐ No ☑

Box 8 – Many patients who have LTOT will have cylinders for ambulatory use or use away from the house – these need to be ordered on a HOOF at the same flow rate as concentrator rate

e.g.



Box 9 – This is for oxygen cylinders for short burst oxygen to relieve exertional breathlessness etc.

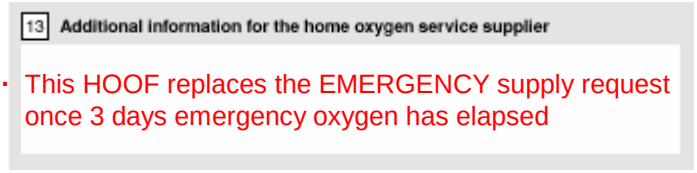
Short burst therapy should be via a Venturi mask normally at 24 –28% for <2 hours/day - be specific with dose – prescribe 24% *or* 28%, not both.
The patient should not be deciding the dose of their drug – this could be dangerous

Do not routinely prescribe nasal cannuale for short burst therapy – fast flow though Venturi mask is required to relieve breathlessness – 24% is normally an ideal dose.

Box 10 – Tick this **ONLY** if EMERGENCY oxygen is required
This is delivered within 4 hours of request
This is a very expensive request – ***if* required fill out a second HOOF and FAX at the same time for on-going need** after the 3 day emergency supply otherwise the supplier will continue to supply EMERGENCY oxygen at a higher tariff.

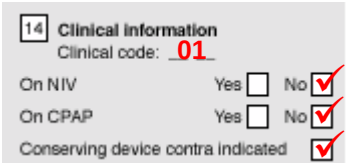
Box 11 – Primary care do not need to fill this out

Box 12 – date must be stated if patient is awaiting LTOT assessment or when ambulatory 2 months assessment period ends



Box 13 – use this space to specify whether this is a concentrator or cylinder patient and to give any other information you feel is required
eg
- holiday data
-information about discontinuing EMERGENCY supply
-a modified HOOF

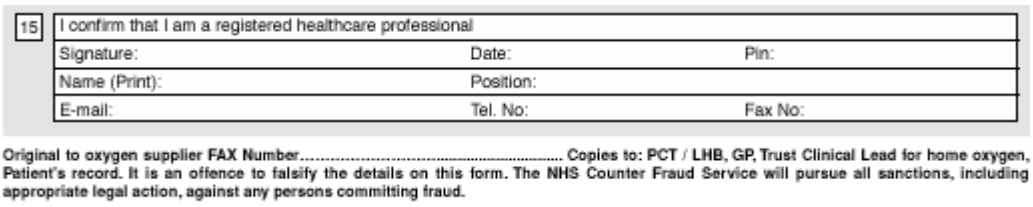
e.g.



Box 14 – Select clinical code for reverse of form and enter

NIV = Non invasive ventilation
CPAP = Continuous positive airways pressure – both are types of assisted ventilation

* **IMPORTANT** to tick conserving device contraindicated – secondary care will be prescribing these after the patient has been assessed using them. If not ticked the patient will receive a conserving device



BOX 15 – prescriber details
Prescribers should be GP, Specialist Nurse or registered Nurse Prescriber.
REMEMBER – oxygen can be harmful, even lethal, if administered inappropriately without due care and attention. If you are uncertain what to prescribe seek specialist advice. PIN number is your GMC, NMC or RCN registration number

The person prescribing the oxygen completes the HOOF and FAXES it to:
-**The new oxygen supply company** – who will send confirmatory return FAX
-**PCT**
-Copy kept in patients notes

-If ordered by secondary care a COPY of HOOF for *information only* to be sent to surgery for patient records