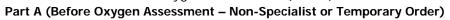
Home Oxygen Order Form (HOOF)





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									olicable)		
1.4 First name*						2.1 Name										
1.5 DoB*					2.2 Tel no.											
1.6 Gender					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				es	□ No	4.2 Practice address:										
3.3 Paedi	☐ Yes ☐		□ No	4.3 Postcode* 4.4 Telephone no												
5. Assessment Service (Ho					(Hosp	pital or Clinical Service) 6. Ward Details (i							ppli	cable))	
5.1 Hospital or Clinic Name:									6.1 Name:							
5.2 Addre				6.2 Tel no.:												
					6.3 Discharge date:											
5.3 Postcode:					5.4	5.4 Tel no:										
	7. Ord	er*	2r*			8. Equipment*						9. Consumables*				
				_	ble	e to select a sta				(select one for each equipment type)			,			
Litres / Min Hours / Day			Day	_	Type	c Concentrator				Quantity	Na	isal Canulae	Ma	ask % an	d Type	
E					8.1 Static Concentrator Back up static cylinder(s) will be supplied as appropri											
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)										10.3 Urgent (4 Hours)						
11. Additional Patient Information									12. Clinical Contact (if applicable)							
									12.1 Name:							
				1	12.2 Tel no. 12.3 Mobile no.											
						13. De	cl	aratior	า*		-					
						rofessional responsible for nd that if I knowingly provi										
												·		roceediii	ys	
* I have completed/or confirm there is a previously signed copy of the Home Oxygen Consent Form HOCF AND the Initial Home Oxygen Risk Mitigation Form IHORM Follow the link to find more help https://www.pcc-cic.org.uk/article/home-oxygen-order-form															r-form	
Name: Profession:																
Signature:								Date: Refer				ed for assessme	nt:	☐ Yes	□ No	
Fax back no. or NHS email address for confirmation / corrections:																
14. Primary Clinical Code																
CODE	Condition				11. 11111101	<u>J</u>	CODE		ondition							
1	Chronic of	ve puli	mona	ary disea	se (COPD)		11	N	leuromuscular disease							
2	Pulmonary	lar dise	ease				12	N	Neurodisability							
3	Severe chronic asthma								O	Obstructive sleep apnoea syndrome						
4	Interstitial lung disease								Cł	Chronic heart failure						
5 Cystic fibrosis									Pa	Paediatric interstitial lung disease						
6 Bronchiectasis (not cystic fibrosis)									Cł	Chronic neonatal lung disease						
7 Pulmonary malignancy								17	Pa	Paediatric cardiac disease						
8 Palliative care								18	CI	Cluster headache						
9 Non-pulmonary palliative care							19	_	Other primary respiratory disorder							
10 Chest wall disease								20	0	Other If no other category applicable						