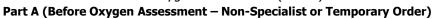
Home Oxygen Order Form (HOOF)





All fields marked with a '*' are mandatory and the HOOF will be rejected if not completed

						1. Pat	tient	Detail	IS							
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						2.2 Tel no.				
1.6 Gender ☐ Male ☐ Female						1.8 Postcode*						2.3 Mobile n	2.3 Mobile no.			
3. Clinical Details						4. Patient's Registered GP Information										
3.1 Clinic	cal Code(s)				4.1 Main Practice name:*										
3.2 Patie	nt on NI	V/CPAP	☐ Ye	es	□ No	4.2 Practice address:										
3.3 Paed	liatric Ord	der	☐ Ye	es	□ No											
						4.3 Postcode* 4.4 Telephone no.										
5. A	ssess	ment	Servi	ice	(Hosp	oital or Clinical Service)					Ward Details (if applicable)					
5.1 Hospital or Clinic Name:									6.1 Name:						,	
5.2 Addr	ess					6.2 Tel no.:										
						6.3 Discharge da					date:	date: / /				
5.3 Posto	code:				5.4 1	Γel no:				, ,						
					8. Equipment*					9. Consumables*						
7. Order*					than 2 hours/day it is advisable to select a st			atic co	ncentrator	(select one for each equipment typ			pe)			
Litres / Min Hours / Day				_	Туре				(Quantity	/ Nasal Canulae Mask % ar			nd Type		
						c Concentrator atic cylinder(s) will be supplied as appropriate										
						c Cylinder(s) /linder will last for approximately 8hrs at 4l/min										
					, , og.c c,	10. Deli			ls*		-					
10.1 Sta	ndard (3	Business	Days)			10.2 Next (Calenda	r) Day				10.3 Urg	ent (4 Hours)]		
11. Additional Patient Information								1	12. Clinical Contact (if applicable)							
						12.1 Name:										
						12.2 Tel no. 12.3 Mot						L2.3 Mobile no	oile no.			
						13. D	ecla	ration	*							
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 confirm that I am the registered healthcare professional responsible for the information provided. I also confirm that the patient has read and signed the Home Oxygen Consent Form.																
Name:		iac che p	acient has read and sign	1	ofession:											
Signature: Do									Referred for assessment: ☐ Yes ☐ No							
		IHS amai	l addrog	ss for	r confirm	ation / corrections:	Dute	·•			recent	24 101 43363311	iiciici	— 163		
T dx bdck	110. 01 1	ii io ciriai	radures	33 101	COMMITTE		linic	al Cod								
CODE	Condition								Condition							
1	Chronic obstructive pulmonary disease (COPD)							12	Neurodisability							
2	Pulmonary vascular disease							13	Obstructive sleep apnoea syndrome							
3	Severe				_		Chronic heart failure									
5	Interstitial lung disease Cystic fibrosis								Paediatric interstitial lung disease Chronic neonatal lung disease							
6 Bronchiectasis (not cystic fibrosis)									Paediatric cardiac disease							
7 Pulmonary malignancy									Cluster headache							
8 Palliative care								19	Other primary respiratory disorder							
9 Non-pulmonary palliative care									Other							
10									Not kr	nown						
11	11 Neuromuscular disease															