BOC

A Member of The Linde Group

BOC HOOF help guide

Must include NHS Number DOB and clinical code

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

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

There must be a name and signature from a qualified clinician

Home Oxygen Order Form (HOOF)

NHS

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

SAMPLE

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	☐ Male ☐ Female	1.8 Postcode*	2.3 Mobile no.

3. Clinical Details

3.1 Clinical Code(s)	
3.2 Patient on NIV/CPAP	☐ Yes ☐ No
3.3 Paediatric Order	☐ Yes ☐ No

4. Patient's Registered GP Information

4.1 Main Practice name:*

4.2 Practice address:

4.3 Postcode*

4.4 Telephone no.

5. Assessment Service (Hospital or Clinical Service)

5.1 Hospital or Clinic Name:

5.2 Address

5.3 Postcode:

5.4 Tel no:

6. Ward Details (if applicable)

6.1 Name:

6.2 Tel no.:

6.3 Discharge date: / /

7. Order*

8. Equipment* For more than 2 hours/day it is advisable to select a static concentrator

9. Consumables* (select one for each equipment type)

Litres / Min	Hours / Day	Type	Quantity	Nasal Canulae	Mask % and Type
		8.1 Static Concentrator Back up static cylinder(s) will be supplied as appropriate			
		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) ☐ 10.2 Next (Calendar) Day ☐ 10.3 Urgent (4 Hours) ☐

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** ☐ **AND** The Initial Home Oxygen Risk Mitigation Form **IHORM** ☐

Name: Profession:

Signature: Date: Referred for assessment: ☐ Yes ☐ 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		

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

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

Must be a % compatible with flow

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

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 superseed the last so please ensure all details are added