HSC Health and Social Care

Oxygen Prescription Form
May only be completed by Prescribers

Home Oxygen Order Form (HOOF (NI)) **Part B (After specialist/paediatric oxygen assessment)**

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

1. Patient Details			
1.1 H & C Number*		1.7 Permanent Address*	1.10 Tel No*
1.2 Title			1.11 Mobile No
1.3 Surname*			1.12 E-Mail
1.4 First Name*			1.13 First Language if not English*
1.5 DOB*		1.8 Postcode*	
1.6 Gender	Male ☐ Female ☐	1.9 Trust	1.14 Interpreter needed?* Yes ☐ No ☐

2. Carer Details (if applicable)	2.1 Name	2.2 Tel No	2.3 Mobile No

3. Clinical Details		**4. Patient's Registered GP Information**	
3.1 Clinical Code(s)		4.1 GP name*	
3.2 Patient on NIV/CPAP	Yes ☐ No ☐	4.2 Practice Name and Address*	
3.3 Paediatric Order*	Yes ☐ No ☐		
3.4 Conserver Appropriate	Yes ☐ No ☐	4.3 Postcode*	4.4 Telephone No*

5. Assessment Service (Hospital or Clinical Service)		**6. Ward Details (if applicable)**
5.1 Trust site	5.2 Hospital/community clinic	6.1 Ward
5.3 Address		6.2 Tel No
		6.3 Discharge Date: / /
5.4 Postcode	5.5 Telephone No	

7. Order* (Total hours/day should not exceed 24 hrs)		**8. Equipment***	Quantity	Conserving device	**9. Consumables*** (tick selection for each equipment type)	
Litres/Min	**Hours/Day**	**Types**			**Nasal Cannula**	**Mask % and type**
		7.1 Static Concentrator Back up static cylinder(s) will be supplied as appropriate				
		7.2 Self Fill Concentrator Same as static concentrator and can fill ambulatory cylinder(s)				
		7.3 Transportable concentrator (trolley based) Can be used in place of a static concentrator and/or for ambulatory use				
		7.4 Portable concentrator (over the shoulder) Lighter weight than transportable concentrator and limited to pulse dose				
		7.5 Standard Ambulatory Cylinder(s) Cylinders for use outside of a home setting				
		7.6 Lightweight ambulatory cylinder Lighter than the standard ambulatory cylinder				
Specialist high usage liquid oxygen (*Should be prescribed for high usage active patients)*						
		7.7 Liquid Oxygen (LOX) Dewar + flask				

10. Additional Equipment	10.1 Humidification (not usually indicated for < 4l/min)	Yes ☐	No ☐	10.2 Tracheostomy (mask only)	Yes ☐	No ☐
11. Delivery Details	11.1 Standard (3 business days) ☐	11.2 Hospital discharge (next Calendar day) ☐		11.3 Urgent (4 hours) ☐		

12. Additional Patient Information	**13. Clinical Contact**
	13.1 Name
	13.2 Tel No / mobile
	14. Expiry date of the prescription for ambulatory cylinders

15. Healthcare Professional Declaration* (may only be completed by a prescriber)

I declare that the information given on this form for HSC 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 confirm that the appropriate consents have been granted for providing this information and that the patient has been advised that their details will be passed to Electricity Distributors and Fire Service.

Name:	Profession:	Professional registration number/GP cipher number:
Signature	Date:	

Fax number for queries/corrections and faxback confirmation:

Fax completed form to **0800 169 9989** and post original by First class post

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Information Notes

Clinical Codes *(please insert relevant codes over page in section 3)*

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 (specify)
10	Chest wall disease	21	Not known
11	Neuromuscular disease		

Guidance notes for prescribers

Ordering

- **This form is a prescription and must be completed by an authorised prescriber. Any forms completed by a healthcare professional who is not a qualified prescriber or by an unauthorised prescriber will be rejected immediately**
- **Fax the signed form to BOC at 0800 169 9989**
- **Post the original signed form by First Class Post to**

BOC Homecare, Prince Regent Road, Castlereagh, Belfast, BT5 6RW.

- **The Prescriber must arrange for the original prescription to be received by BOC within 72 hours of placing the order**

Delivery

- **Most orders should be placed for the normal delivery timescale i.e. 3 business days.**
- **Orders for next day delivery should only be placed if necessary to facilitate hospital discharge**
- **Orders for urgent 4 hour delivery should only be placed to meet urgent Oxygen requirements.**

Part A should be completed for orders required before specialist oxygen assessment and for non-specialist or temporary orders

Part B should be completed for orders required following specialist oxygen assessment or paediatric oxygen assessment

Orders for ambulatory oxygen cylinders

- **The prescriber should specify the expiry date for a prescription for ambulatory oxygen cylinders in section 14. This date should not exceed 12 months from the date of the prescription**

It is the prescriber's responsibility to complete the form legibly and supply all the necessary information for BOC to enable supply in a timely fashion. Missing information may result in delays for the patient.

Failure to complete mandatory fields will result in immediate rejection of the order

Prescribers should notify the patient's general practitioner that oxygen has been ordered for the patient and provide the details for their clinical records

Relevant consents from each patient should be obtained for sharing patient information

A termination order should be faxed to BOC if the oxygen as specified in the HOOF is no longer required e.g change in clinical circumstances necessitating a new HOOF, patient deceased.

Prescribers and healthcare professionals should notify BOC of any change in temporary or permanent address for a patient who has been prescribed oxygen using a HOOF Part A or B