



# Home Oxygen Order Form (HOOF-P)

Please pick one:  New Install  Prescription Renewal  Holiday

Section 1. Service User Details													
Do you have a HSE eligibility card(s)? <input type="checkbox"/> GMS <input type="checkbox"/> DPS <input type="checkbox"/> Card No: <input type="text"/> No													
First Name:							Surname:						
Permanent Address:													
<sup>1</sup> Delivery Address (if different from above):													
Eircode:							D.O.B.:						
Mobile No.:							Contact Tel. No.:						
First Language if not English:							Interpreter Needed? <input type="checkbox"/> Yes <input type="checkbox"/> No						
G.P. Name:							G.P. email:						
<sup>2</sup> Agreement form filed in service users medical notes? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Section 2. Carer/ Emergency Contact Details (if applicable)													
Name:							Contact Tel. No.:						
Section 3. Clinic Details													
Clinical Code Number <i>(enter code number as per relevant condition in appendix II):</i>													
Service user on NIV/ CPAP? <input type="checkbox"/> Yes <input type="checkbox"/> No							Oxygen entrainment required? <input type="checkbox"/> Yes <input type="checkbox"/> L/min <input type="text"/> <input type="checkbox"/> No						
<sup>3</sup> Primary prescription complete? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Smoking status in home:													
Section 4. Hospital Details													
Hospital:							Ward:						
Contact No.:							Estimated discharge date:						
Consultant Name:							<sup>4</sup> Service contact email*:						
Section 5. Name and details of primary prescriber													
Prescriber:							Prescriber email:						
MCRN/ NMBI PIN:				Start Date				Renewal Date					
Prescription start/ renewal date:													
Section 6. Order													
<b>Stationary equipment</b>			<b>Hrs/day</b>		<b>L/min</b>		<b><sup>5</sup>Ambulatory equipment</b>			<b>Hrs/day</b>			
Standard concentrator 1-5L							No ambulatory source			SETTING		L0	
							Portable concentrator			SETTING		L3	
							Transportable concentrator			SETTING		L4	
							1-4 cylinders per month			L/min		L5	
							1-8 cylinders per month			L/min		L1	
							1-12 cylinders per month			L/min		L2	
							Homefill system with 2 cylinders			L/min		S1	
							Homefill system with 4 cylinders			L/min		S2	
							Liquid oxygen (1 flask)			L/min		LOX2	
High flow concentrator 1-9L							No ambulatory source			SETTING		L01	
							Portable concentrator			SETTING		L7	
							Transportable concentrator			SETTING		L8	
							1-12 cylinders per month			L/min		L6	
							Liquid oxygen (2 flasks)			L/min		LOX1	
Ambulatory Oxygen Therapy Package (AOT)							Portable concentrator only			SETTING		A5	
							Transportable concentrator only			SETTING		A4	
							1-4 cylinders only per month			L/min		A1	
							1-8 cylinders only per month			L/min		A2	
							1-12 cylinders only per month			L/min		A3	
							Liquid oxygen (1 flask)			L/min		LOX3	
Neonate package (static cylinder)							1-4 cylinders per month			L/min		L11	
							No ambulatory source					L11	
Paediatric concentrator (0.1-1L)							1-6 cylinders per month			L/min		L10	
							No ambulatory source					L10	

**Section 6. Order (cont'd)**

Short burst package (static cylinder)

L/min 

1-6 cylinders per month

L/min 

L9

No ambulatory source

L9

**Additional Details (please tick)**

Nasal Cannula – please select from below

Additional LOX Flask

LOX4

Neonate

Additional LOX Refill

LOX5

Infant

Additional stationary concentrator

L0

Paediatric

°Heated humidifier (e.g. Airvo)

H1

Standard

Heated humidification pack

H2

High-flow &gt;6L/min

Holiday risk assessment

HOL1

Mask needed - what type? Overquota of cylinders (must be multiples of 4) QTY 

A1, A2, A3

Contraindication for conserver

Homefill individual cylinder

QTY 

S3

(pulse mode) - tick if contraindicated.

**Comments:****Section 7. Delivery Details (please tick)**<sup>7</sup>Standard (within 3 days of order):<sup>8</sup>Emergency\* (same day): Yes  No *\*Emergency (same day) installed before midnight on day of order***Section 8. Healthcare Professional Declaration**

<sup>9</sup>I declare that the information given on this form is correct and complete. I confirm that the appropriate consent and prescription has been obtained and that the service user has been advised that their details will be passed to the oxygen supplier.

Name: Profession: Professional Reg. No: Contact Tel. No: Date: Secure email address: Signature **<sup>10</sup>Local Health Area Only:**Approved By: Approver email: Date: PO Number: Region: Integrated Health Area: Signature **Guidance notes for completing HOOF-P**

1. Prescriber and healthcare professionals should notify HSE of any change in temporary or permanent address for a service user who has been prescribed oxygen using a HOOF-P.
2. Relevant signed consents from each service user/ parent/ legally appointed person should be obtained and stored in service user file to allow sharing of service user information.
3. Non-prescribing specialist staff may complete the HOOF-P once a primary prescription is in place and they have adequate training to do so.
4. Service contact email is the email to which notification of need for prescription renewal and/or any matter pertaining to the service user will be sent.
5. Service users requiring ambulatory oxygen therapy can be prescribed as per section 6.
6. If a service user requires specialist heated ventilation in addition please complete separate request.
7. Orders should be placed for the standard delivery timescale i.e. within 3 days.
8. **Emergency orders (same day installation)** should only be selected in case of **emergency**. Most installations happen within 1 to 3 days. Making necessary arrangements for emergency installation on the same day can be challenging for service users and their families/carers.
9. It is the responsibility of those completing the form that it is legible and supplies all the necessary information required. Missing information will result in delays for the service user. Failure to complete mandatory fields will result in rejection of the order.
10. Medical Card holders: HOOF-P is to be sent to local HSE offices for approval. Non-medical card holders: HOOF-P can be sent directly to supplier.
11. A termination order should be sent to relevant HSE Office if the oxygen, as specified in the HOOF-P, is no longer required e.g. change in clinical circumstances necessitating a new HOOF-P or no longer requires oxygen (including RIP).

## Appendix II

<b>Code</b>	<b>Condition</b>
1	Chronic obstructive pulmonary disease (COPD)
2	Pulmonary vascular disease
3	Severe chronic asthma
4	Interstitial lung disease
5	Cystic fibrosis
6	Bronchiectasis (not cystic fibrosis)
7	Pulmonary malignancy
8	Palliative care
9	Neuromuscular disease
10	Neurodisability
11	Obstructive sleep apnoea syndrome
12	Obesity hypoventilation syndrome
13	Chronic heart failure
14	Cluster headache
15	Chronic lung disease of prematurity
16	Congenital cyanotic heart disease
17	Long term ventilation
18	Other or not known