



Home Oxygen Order Form (HOOF-P)

Please tick one:

New install

Transition

Section 1. Service User Details

Do you have a HSE eligibility card(s)? ☐ GMS ☐ LTI ☐ DPS Card No: No

First Name: Surname:

Permanent Address:

Delivery Address (if different from above):

Eircode: D.O.B.

Mobile No.: Contact Tel. No.:

First Language if not English: Interpreter Needed? Yes ☐ No ☐

G.P. Name: G.P. email:

Agreement form filed in service users medical notes? Yes ☐ No ☐

Section 2. Carer/ Emergency Contact Details (if applicable)

Name: Contact Tel. No.:

Section 3. Clinic Details

Clinical Code Number (enter code number as per relevant condition in **appendix II**):

Service user on NIV/ CPAP? Yes ☐ No ☐ Oxygen entrainment required? Yes ☐ L/min No ☐

Primary prescription Complete? Yes ☐ No ☐

Smoking status in home:

Section 4. Hospital Details

Hospital: Ward:

Contact No.: Estimated discharge date:

Consultant Name:

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

Stationary equipment	Hrs/day	Ambulatory equipment	Hrs/day	
Standard concentrator 1-5L	L/min <input type="text"/>	No ambulatory source		L0
		Portable concentrator	SETTING <input type="text"/>	L3
		Transportable concentrator	SETTING <input type="text"/>	L4
		1-4 cylinders per month	L/min <input type="text"/>	L5
		1-8 cylinders per month	L/min <input type="text"/>	L1
		1-12 cylinders per month	L/min <input type="text"/>	L2
		Homefill system with 2 cylinders	L/min <input type="text"/>	S1
		Homefill system with 4 cylinders	L/min <input type="text"/>	S2
		Liquid oxygen (1 flask)	L/min <input type="text"/>	LOX2
High flow concentrator 1-9L	L/min <input type="text"/>	No ambulatory source		L01
		Portable concentrator	SETTING <input type="text"/>	L7
		Transportable concentrator	SETTING <input type="text"/>	L8
		1-12 cylinders per month	L/min <input type="text"/>	L6
		Liquid oxygen (2 flasks)	L/min <input type="text"/>	LOX1
Ambulatory Oxygen Therapy Package (AOT)		Portable concentrator only	SETTING <input type="text"/>	A5
		Transportable concentrator only	SETTING <input type="text"/>	A4
		1-4 cylinders only per month	L/min <input type="text"/>	A1
		1-8 cylinders only per month	L/min <input type="text"/>	A2
		1-12 cylinders only per month	L/min <input type="text"/>	A3
		Liquid oxygen (1 flask)	L/min <input type="text"/>	LOX3
Neonate package (static cylinder)	L/min <input type="text"/>	1-4 cylinders per month	L/min <input type="text"/>	L11
		No ambulatory source		L11
Paediatric concentrator (0.1-1L)	L/min <input type="text"/>	1-6 cylinders per month	L/min <input type="text"/>	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 >6L/min			Holiday Risk Assessment		HOL1	
Mask needed - what type?					QTY	
Conservator required? Yes No			Overquota of cylinders (must be multiples of 4)		QTY	
			Homefill individual cylinder		QTY	

Comments

Section 7. Delivery Details (please tick)

Standard (3 working days):

Emergency (Same Day) Yes No

Section 8. Healthcare Professional Declaration

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:	
Community Health Area Only:		
Approved By:	Approver email:	
Date:	PO Number:	CHO:
Signature:		

Appendix I - Guidance notes for completing HOOF-P

- Medical Card holders HOOF-P is to be sent to local HSE offices, according to contracted area, for approval. HOOF-P for non-medical card holders can be sent directly to supplier.
- Non-prescribing specialist staff may complete the HOOF-P once a primary prescription is in place and they have adequate training to do so.
- Service users requiring ambulatory oxygen therapy can be prescribed as per section 6.
- If a service user requires specialist heated ventilation in addition please complete separate request.
- Orders should be placed for the normal delivery timescale i.e. 3 business days.
- Orders for same day delivery** should only be placed in cases of emergency and if longer pre-planning not feasible. Making necessary arrangements in this time frame can be challenging for service users and their families/carers.
- 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.
- 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.
- 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).
- Prescribers 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.

Appendix II - Clinical Codes

Code Condition

- 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