Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Irish Thoracic Society

electronic Home Oxygen Order Form (eHOOF)

All fields marked with a "*" are mandatory. The HOOF will be rejected if not complete.

1. Patient Details							
1.1 GMS/LTI/DPS Number:*		1.7 Permanent Address:*		1.9 Tel No:*			
1.2 Title:				1.10 Mobile No:*			
1.3 Surname:*				1.11 E-Mail:			
1.4 First Name:*				1.12 First Language if not English:*			
1.5 DOB:*							
1.6 Gender: Male:	Female:	1.8 Local Office*:		1.13 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)*(P.T.O)					4.1 GP name:*			
3.2 Patient on NIV/CPAP	Yes:		No:		4.2 Practice Name and Address:*			
3.3 Oxygen entrainment reqd?	Yes:		No:					
3.4 Conserver Appropriate	Yes:		No:		4.3 Email:		4.4 Phone:	

5. Assessment Service (Hospital or Clinical Service)				**6. Ward Details (if applicable):**	
5.1 Hospital*		5.2 Consultant*		6.1 Ward:	
5.3 Address				6.1 Tel No:	
				6.3 Discharge Date::	

7. Order:*(Total hrs/day should not exceed 24)		**8. Equipment:***	**Conserving device:**	**9. Consumables:*** (tick selection for each equip type)	
Litres/Min: (or Setting for Pulsed)	**Hrs/Day**	**Types:**		**Nasal Cannula**	**Mask % & type**
		8.1 Static Concentrator (Higher flow rates indicate high flow machines) Back up static cylinder(s) supplied as appropriate	N/A		
		8.2 Self Fill Concentrator Same as static concentrator and can fill ambulatorycylinder(s)			
		8.3 Transportable concentrator (trolleybased) Can be used in place of a static concentrator (short term) and/or for ambulatory	N/A		
		8.4 Portable concentrator (over theshoulder) Lighter than transportable concentrator and limited to pulse dose [Mask n/a with pulse dose]	N/A		
		8.5 Standard Ambulatory Cylinder(s) Cylinders for use outside of a home setting [Mask n/a with pulse dose]			
		8.6 Lightweight ambulatory cylinder Lighter than the standard ambulatory cylinder [Mask n/a with pulse dose]			
Specialist high usage liquid oxygen: (*Prescribed for high activity patients*)					
		8.7 Liquid Oxygen (LOX) Dewar(s) + flask(s) *please specify requirements in section 12*			

10. Additional Equipment:	10.1 Humidification: (not usually indicated for < 4L/min)	Yes		No		10.2 Tracheostomy: (mask only)	Yes		No	
11. DeliveryDetails:	11.1 Standard (3 business days)			11.2 Emergency (next business day)(**in exceptional circumstances only–see over)**						
12.1 Is the patient a current smoker:*	Yes		No			**13. Clinical Contact:***				
12.2 Additional Information:						13.1 Name:				
						13.2 Tel No / mobile:				
						13.3 Email:				

14. Healthcare Professional Declaration* (may only be completed by prescriber/Respiratory specialist)					
I declare that the information given on this form is correct and complete & 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 obtained & that the Patient/Patient's parent/Patient's legal guardian has been advised that their details will be passed to the oxygen supplier and (in the case of Medical card/LTI holders) to HSE.					
Name:		Profession:			
Signature:			Date:		
Fax number for queries/corrections and faxback confirmation:					

Fax/email completed signed form to Local Appliance Office (formerly known as LHO/CCA) for medical card/LTI card patients. For non-medical card holders/LTI fax or email directly to supplier.

Air Liquide Ireland ltd - oxygen.A@healthmail.ie

BOC Healthcare Ireland - oxygen.B@healthmail.ie

As this is a legal document - file in patient's notes. Send details or a copy to the patient's G.P.

Information Notes

Clinical Codes *(please insert relevant codes in section 3.1 over page)*			
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	Obesity Hypoventilation Syndrome
4	Interstitial lung disease	15	Chronic heart failure
5	Cystic fibrosis	16	Cluster headache (Equipment to be requested in 12.2)
6	Bronchiectasis (non cystic fibrosis)	17	Other primary respiratory disorder
7	Pulmonary malignancy	18	Other (specify)
8	Palliative care	19	Chronic lung disease of prematurity
9	Non-pulmonary palliative care	20	Congenital cyanotic heart disease
10	Chest wall disease	21	Long term ventilation
11	Neuromuscular disease	22	Other or Not known

Guidance notes for prescribers

- This form is a prescription and must be completed by an authorised prescriber/respiratory specialist i.e.: Consultant, CNSp or Physiotherapist.
- Patients requiring ambulatory oxygen therapy can be prescribed as **PRN** in column 7 (Hrs/Day)
- If a patient requires specialist heated ventilation in addition please complete separate order form.
- Orders should be placed for the normal delivery timescale i.e. 3 business days.
- **Orders for next day delivery** should only be placed in cases of emergency and if longer pre-planning not feasible. Making arrangements in this time frame can be challenging for patients and their families/carers and can bring added cost.
- It is the prescriber's responsibility to complete the form legibly and supply all the necessary information for supplier. **Missing information will result in delays for the patient.** Failure to complete mandatory fields will result in rejection of the order.
- A termination order should be faxed to Local Appliance Office (see footer) if the oxygen as specified in the HOOF is no longer required e.g. change in clinical circumstances necessitating a new HOOF or no longer requires oxygen (including RIP).

15. Information Provided to Patient/Patient's Parent/Patient's Legal Guardian	**Tick**		**Comments**
Fire safety precautions have been discussed	Yes	No	
Advised to never use oxygen concentrator or cylinders near a naked flame	Yes	No	
Advised to never smoke while using oxygen concentrators or cylinders (in case of adults)	Yes	No	
Advised to complete ESB priority support customer registration form and how/where to access same.	Yes	No	Company will also do this
The oxygen company's information & safety booklet was provided	Yes	No	Or Company supply directly
Advised to inform home insurance company that he/she/his/her child is currently using oxygen therapy	Yes	No	
Advised to inform his/her car insurance company that he/she is currently using oxygen therapy	Yes	No	N/A for Paediatrics
Advised that company will provide training including booklet to patient, family/carers at time of installation	Yes	No	

16. Patient/Patient's Parent/Patient's Legal Guardian Acknowledgement and Consent

- I have been provided with and understand the education on the safe use of oxygen therapy as outlined above.
- I understand as part of the arrangements for providing oxygen at home that this document, setting out the contact details and medical information regarding my/my child's medical condition will be shared with the oxygen provider.
- I understand that if my/my child's medical card/LTI status changes, that I should contact the oxygen supplier.
- I understand that the HSE may also notify the oxygen supplier of any change in my/my child's medical card/LTI status
- I understand that a clinical review may be performed of my/my child's oxygen requirements following its installation.
- **Note:** If at this time – or any other time in the future – it is decided that oxygen therapy is no longer necessary I understand the oxygen will be cancelled and will provide access to the oxygen supplier to remove the equipment from my home/the premises.
- **Note:** If I fail to comply with the training and instruction given surrounding the safe use of oxygen at home, I agree that my/my child's oxygen equipment may be removed at any point in the future, for health and safety reasons.
- I understand that the oxygen, and equipment for its use, comes from a third party supplier. In the event of any breakages or difficulties

relating to the equipment or oxygen provided, I understand that I should contact the oxygen supplier.

16.1 Patient/Parent/ Legal Guardian Signature: ____________________________________Name (PRINT):____

16.2 Witness obtaining consent and providing information: Name: _____________________________________ Date: ___________/_________/___________

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