BOC
A Member of The Linde Group

BOC HOOF Help Guide Part B

Please provide the address of which you require the delivery to be made.

Must include NHS number, DOB and clinical code.

Must be a numerical value no greater than 24hpd. If adding an ambulatory item the whole form must not exceed 24hpd.

A transportable concentrator is an ambulatory piece of equipment and should only be prescribed for up to 10hpd.

A portable concentrator must be prescribed on a setting not LPM. The patient should be assessed on this piece of equipment.

There must be a name and signature of a qualified clinician.

Please provide the patient/carer/next of kin contact numbers. Please provide all contact details available. If there is an emergency contact please also provide this.

Please inform the main contact to expect a call from BOC to complete the phone based risk assessment and arrange the oxygen installation.

GP information must be provided to ensure an account is aligned to the correct CCG.

Ward details with phone numbers ensures we can contact you as soon as possible if there is an issue with the form.

Please tick if a nasal cannula is required. If a mask is needed a suitable venturi % must be written. The form must contain a consumable.

Humidification should be prescribed for trachea patients only. If humidification is indicated, please discuss with BOC clinical advisor first.

Important: both check boxes MUST be completed or the HOOF will be rejected.

Home Oxygen Order Form (HOOF)
Part B (After Specialist / Paediatric Oxygen Assessment)
All fields marked with a '*' are mandatory and the HOOF will be rejected if not completed

NHS

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 / **4. Patient's Registered GP Information**

3.1 Clinical Code(s)		4.1 Main Practice name:*
3.2 Patient on NIV/CPAP	☐ Yes ☐ No	4.2 Practice address:
3.3 Paediatric Order	☐ Yes ☐ No	
		4.3 Postcode* 4.4 Telephone no.

5. Assessment Service (Hospital or Clinical Service) / **6. Ward Details (if applicable)**

5.1 Hospital or Clinic Name:	6.1 Name:
5.2 Address	6.2 Tel no.:
	6.3 Discharge date: / /
5.3 Postcode: 5.4 Tel no:	

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	Conserving Device	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				
		8.3 Self Fill Concentrator Same as static concentrator and can fill ambulatory cylinder(s) (8.5/8.6)				
		8.4 Transportable Concentrator (trolley based) Can be used in place of a static concentrator and / or for ambulatory use				
		8.5 Standard Ambulatory Cylinder(s) Cylinders for use outside of a home setting				
		8.6 Lightweight Ambulatory Cylinder(s) Lighter than the standard ambulatory cylinder				
		8.7 Portable Concentrator (carry over shoulder) Lighter weight than transportable concentrator and limited to pulse dose				
		8.8 Liquid Oxygen (LOX) Dewar Please select number of flasks required below				
		8.9 Liquid Oxygen (LOX) Flask To be used in conjunction with the LOX Dewar				

10. Additional Equipment

10.1 Humidification (not usually indicated for less than 4l/min) ☐ Yes ☐ No | 10.2 Tracheostomy (mask only) ☐ Yes ☐ No

11. Delivery Details*

11.1 Standard (3 Business Days) ☐ | 11.2 Next (Calendar) Day ☐ | 11.3 Urgent (4 Hours) ☐

12. Temporary Secondary Supply (e.g. Holiday Order with different modality) / **13. Contact Details** (if applicable)

12.1 Address: Postcode: | 13.1 Name: | 13.2 Tel no.

14. Additional Patient Information / **15. Clinical Contact (if applicable)**

15.1 Name: | 15.2 Tel no. | 15.3 Mobile no.

16. 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've completed/ or confirm there is a previously signed copy of the Home Oxygen consent form HOCF ☐ AND an Initial Home Oxygen Risk Mitigation Form IHORM ☐

Name: | Profession:
Signature: | Date:
Fax back no. or NHS email address for confirmation / corrections:

A next day request should be used for hospital discharges. A 4 hour request should only be used in an emergency situation.

Providing a secure NHS email address ensures you will receive confirmation that your order is being processed.

All prescriptions superseed the last so please ensure all details are added

For Paediatrics with a varied flow a start flow MUST be stated in section 14