**Sections to be completed by patient**

|  |
| --- |
| **Patient’s Details** |
| Patients Name & Address(Including postcode) |  |
| Patient’s Telephone Number |  |
| Property Type | House, low rise flat, other (Circle as appropriate) |
| Pick up point | Side gate/ front door/ please knock/ Other (Circle as appropriate) |

Signed (resident)……………………………………………………………..………. Date……………………………….

**Sections to be completed by a Healthcare professional – Strictly Confidential**

|  |  |
| --- | --- |
| 1 | Does a Health care professional administer (please circle) YES NO**If Yes - please note that it is the responsibility of Healthcare professional to dispose of this waste** |
| 2 | Does the patient require Sharps box(s) to be supplied by contractor (please circle) YES NOIf yes, please circle the size of Sharps box required 1 Litre 4 Litre 7 Litre |
| 3. | Does the patient require clinical waste bags to be supplied YES NOIf yes, please provide quantity needed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Details of waste to be collected** |
| 4 | **Sharps box** | Size (please circle) | 1 Litre | 4 Litre | 7 Litre |
| 5 | Frequency of collection: | (Please circle) | Weekly  | Fortnightly | Other – (specify) |
| 6 | **Clinical Waste bags** | Please specify quantity to be collected |  |
| 7 | Frequency of collection: | (Please circle) | Weekly  | Fortnightly | Other – (specify) |
| **OFFENSIVE WASTE****Please note this waste is not infectious and does not require specialist clinical waste disposal and can be placed in the residual waste.** |
| 6 | Any other relevant information: |
| **Originators Details** |
| Healthcare Professional(Print Name) |  |
| Contact Telephone No |
| Address |  |

Signed (Healthcare professional)……………………………………………….. Date………………………………………………

**Sections to be completed by Tendring District Council**

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| --- | --- |
| Local Authority Reference Number | TDC/ |
| Date |  |