Reference number if known	
Date:	

Sections to be completed by a Healthcare Professional – Strictly Confidential

PATIENT'S DETAILS		
NHS Number		
Patient's Name & Address (Including Postcode)		
Patient's Telephone Number		**Patients Email:**

DETAILS OF WASTE			**Type:**	**Diabetes**	**Pain Relief**	**Other**
1	**YELLOW SHARPS BOX**	Infectious sharps contaminated with medicines				
2	**YELLOW SHARPS BOX PURPLE LID**	Infectious sharps contaminated with cytotoxic / cytostatic products				
3	**ORANGE SACK**	Infectious waste that can be treated		**Yes / No (circle appropriate) See Section 6**		
4	**OFFENSIVE WASTE**	Please note this waste is not infectious and **does not** require specialist treatment or disposal and can be place in your residual wheelie bin. Should you require extra capacity please refer to our larger capacity policy on the website or contact Admin on 01992 564000 for a separate form.				
5	**DO YOU/THE PATIENT SELF-ADMINISTER:** This includes if your partner/wife/husband/son/daughter/mother/father does this for you, **but not** if a healthcare professional or carer administers for you **(please circle answer)**			YES		NO
6	**Please provide a brief description of the clinical waste and any other relevant information**					
For definitions refer to HTM 0701Safe Management Healthcare Waste (Sector Guides) Community Nursing Para 17-34 inclusive						
Confirm that this is the patient's waste			YES		NO	

Property type: - House, low rise flat, high rise flat, other. (Circle as appropriate).

Pick up point: - Side gate, front door, please knock. (Circle as appropriate).

Likely number of sacks/boxes per collection. 1–5 5-10 10-15 (Circle as appropriate).

Likely frequency: - One off , Adhoc on request, Weekly, fortnightly, monthly. (Circle as appropriate).

Likely duration of requirement: - 0 -12 months, 12- 24 months. 24- 36 months, Indefinitely , other please specify – example one off : …….. (Circle as appropriate).

Currently Epping Forest District Council does not charge for this service, however, this may be subject to change and may be chargeable in the future. Three months notice may be given.

Signed (Resident) ……..… Date ……..…..

"By signing this application you are agreeing for EFDC to share your personal information with your healthcare professional and any other third party that may need to be involved with this application".

PLEASE ASK YOUR HEALTHCARE PROFESSIONAL TO COMPLETE PAGE 2 BEFORE RETURNING THIS FORM TO US

ORIGINATOR'S DETAILS			
Healthcare Professional (Print Name)			
Contact Telephone Number		**Email Address**	
Address			

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

Return completed form by email to Neibackoffice@eppingforestdc.gov.uk or to post to :

Waste Management, Civic offices, 323 High Street, Epping, Essex, CM16 4BZ