

Clinical Waste Application Form

You **do not** need a separate clinical waste collection if the following applies:

- The waste includes wound dressings, sanitary towels, incontinence pads or nappies and emptied stoma and catheter bags. These items can all be disposed of into your purple bin. The only exception to this is if the waste is from someone carrying an infection.
- You are treated at home by a nurse or healthcare professional – who should take any waste arising from dressings, medications, etc. away with them

A separate clinical collection will only be provided if the waste is infectious, as confirmed by a healthcare professional.

If the waste produced is associated with cytotoxic and cytostatic medicines it is unlikely that we will be able to collect it. For more information please contact us.

If you require a sharps box collection, please register by phoning 0800 328 6023.

Section 1: Resident's Details

Title: _____ Name: _____

Address: _____

Telephone: _____ E-mail: _____

I require a collection of **infectious** waste for the following items: *(Please tick all which apply)*

Incontinence pads / nappy waste	<input type="checkbox"/>
Swabs and/or wound dressings	<input type="checkbox"/>
Stoma/ catheter bags	<input type="checkbox"/>
Other waste- Please provide further details below	<input type="checkbox"/>

Supporting information and declaration

Please provide any other details which you feel we may find useful in correctly identifying and disposing of the waste safely.

I confirm that the information I have provided on this form is accurate and should my circumstances change or I move address, I will inform the council.

Resident signature: _____ Date: _____

Please pass this form to your healthcare professional, this can be a care worker, community nurse or doctor. They will need to complete the reverse of this form to ensure the waste is correctly identified and disposed of accordingly.

Section 2: To be completed by a Healthcare Professional

Name: _____

Position: _____

Organisation: _____ Telephone: _____

E-mail: _____

Preferred method of contact: _____

a) I confirm that the person named above requires a collection of **infectious** waste

b) I anticipate the person named above will require specialist collection for infectious waste for the following duration:

Up to 6 weeks	Up to 3 months	Up to 6 months	Over 6 months

c) Approximately what quantity of waste requiring specialist disposal would you anticipate the named person above to produce weekly?

1 small carrier bag	
Up to 1 large sack/ bag	
2 to 3 large sacks/ bags	
More than 3 large sacks/ bags	

I confirm the waste described is an accurate description of the needs of the resident, to ensure waste is disposed of correctly in accordance with the waste 'duty of care'.

Healthcare professional signature: _____ Date: _____

This information will be shared with our collection contractor to provide requested services and securely destroyed when services are no longer required. For residents of Sheltered Housing Schemes, we may share this information with your scheme manager to facilitate provision, storage and collection of sacks.

This data will be dealt with in accordance with the Data Protection Act 1998 and will be used for the purposes of compliance with NHDC policy and for service delivery.

If you require further information or help completing this form please contact us:
0800 328 6023

Please return this form to:

North Hertfordshire District Council,
C/O Veolia,
Works Road,
Letchworth Garden City,
SG6 1LP