

WASTE ASSESSMENT FORM

SECTIONS A & B: (To be completed by Health Care Professional or Practice Stamp and emailed to relevant WCA contact)

SECTION A: WASTE ASSESSOR DETAILS

NAME: _____ DATE: _____ TIME: _____

CONTACT ADDRESS: _____

Tel No: _____

SECTION B: Details of the person for whom waste has been assessed

TITLE: _____ FIRST NAME: _____

SURNAME: _____

COLLECTION ADDRESS: _____

Tel No: _____

Date Service Required From: _____ to _____

Collection Frequency: Weekly Intermittent i.e. sharps
One-off

Collection point if known (e.g. front doorstep) _____

Estimated Quantity per week:
Less than half bag Half bag
One bag Two bags or more

WASTE CATEGORIES: TICK APPROPRIATE BOX:

Infectious Offensive/Hygiene

For Sharps collections the WCA will only collect from housebound patients.

Please confirm that this patient is housebound: Yes

**Please note: WCA's do NOT offer a disposal service for pharmaceutical products or clinical waste generated by treatment with cytotoxic or cytostatic drugs. These items should be taken back to the surgery / hospital that prescribed the treatment.

SECTION C: (To be completed by Waste Collection Authority)

DATE RECEIVED: _____

RECEIVING OFFICER: _____

Referred to: _____

Service explained to Customer by: Telephone Letter Visit

Date: _____

Selected Collection Option: Existing Bin Larger Bin

Additional Bin Separate Collection

If a Separate Collection is required:

Where will the sack be presented?

Date Contractor Notified: _____

Instruction/Order Number: _____