

HandHygiene4U

Practice Survey



Name & Address

Telephone:

e-mail:

Fax:

Post Code

Contact Name:

Practice Details: By Room / Area

Additional comments

Number of Surgeries, This includes all surgeries even if not currently used or are only part time

Number of Decontamination / Sterile Rooms

Number of X Ray / Processing Rooms

Number of Toilets / Staff and Visitor (Note this is not the number of cubicals but the number of hand washing stations within each toilet

Number of Kitchens

Number of Staff Changing Rooms

Number of Office and Admin Areas / Rooms

Number of Reception Areas plus number of reception points on the frontage

Number of Waiting rooms / Areas

Number and type of use for any other rooms within the practice - Please Give details:

Please complete this form, we will then be able to provide a quotation based on this information ensuring your practice can achieve the "Best Practice" standard as outlined within the HTM01-05. Included with the quotation will be detailed a guide on placement and the reasons why. **PLEASE FAX. E-MAIL OR POST THE COMPLETED FORM ALONG WITH YOUR SIGNED DISPENSER PLACEMENT FORM SO WE CAN PROVIDE FREE DISPENSERS**

Signed:

Date: