Nuisance record of drug smells

Delivered:

Collected:

Your details	**Neighbours details**
Name:	Name:
Address:	Address:

Keep a record of each incident of odour that you experience

Date of smell	**Time of smell**	**Where do you think the smell is coming from?**	**What does it smell like?**	**How did it affect you?** For example, does it give you a headache?	**How strong was the smell?** (see scale 1-5 below)	**How long did it go on for?**	**Was it constant or intermittent in this period?** Check every three minutes if possible.	**What do you believe the source/ cause to be?**	**Any actions taken or other comments**

Strength of smell

1 - No detectable smell **2** - Faint smell (barely detectable, need to stand still and inhale) **3** - Moderate smell (easily detected while walking and breathing normally)

4 - Strong smell **5** - Very strong smell (possibly causing nausea)

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