Odour Diary					Form version 110319	Sheet No
Name: Telephone Number:	Address:					
Date of odour:						
Time of odour:						
Location of odour, if not at above address (indoors, outside):						
Weather conditions (dry, rain, fog, snow etc):						
Temperature (very warm, warm, mild, cold or degrees if known):						
Wind strength (none, light, steady, strong, gusting):						
Wind direction (eg from NE):						
What does it smell like? How unpleasant is it? Do you consider this smell offensive?						
Intensity – How strong was it? (see below 1-5):						
How long did go on for? (time):						
Was it constant or intermittent in this period:						
What do believe the source/cause to be?						
Any actions taken or other comments:						

Intensity

0 No odour
1 Very faint odour
2 Faint odour
3 Distinct odour
4 Strong odour
5 Very strong odour
6 Extremely strong odour