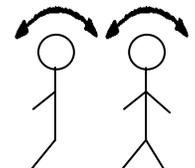
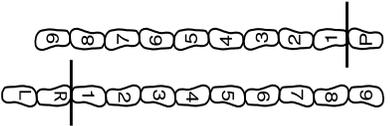
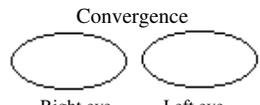
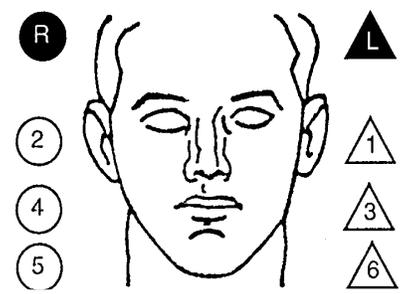
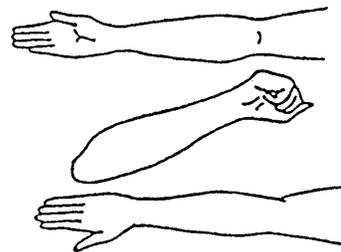
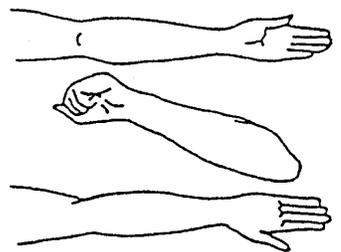


# DRUG INFLUENCE EVALUATION

Evaluator		DRE #	Rolling Log #	Evaluator's Agency										
Recorder/Witness		Crash: <input type="checkbox"/> None <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property		Arresting Officer's Agency										
Arrestee's Name (Last, First, Middle)		Date of Birth	Sex	Race	Arresting Officer (Name, ID#)									
Date Examined / Time /Location / /		Breath Results: Test Refused <input type="checkbox"/> Results: Instrument #:		Chemical Test: Urine <input type="checkbox"/> Blood <input type="checkbox"/> Test or tests refused <input type="checkbox"/>										
Miranda Warning Given Given By:	<input type="checkbox"/> Yes <input type="checkbox"/> No	What have you eaten today? When?	What have you been drinking? How much?	Time of last drink?										
Time now/ Actual	When did you last sleep? How long	Are you sick or injured? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you diabetic or epileptic? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have any physical defects? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you under the care of a doctor or dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No										
Are you taking any medication or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Attitude:		Coordination:										
Speech:		Breath Odor:		Face:										
Corrective Lenses: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft		Eyes: <input type="checkbox"/> Reddened Conjunctiva <input type="checkbox"/> Normal <input type="checkbox"/> Bloodshot <input type="checkbox"/> Watery		Blindness: <input type="checkbox"/> None <input type="checkbox"/> Left <input type="checkbox"/> Right										
Pupil Size: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal (explain)		Vertical Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No		Able to follow stimulus <input type="checkbox"/> Yes <input type="checkbox"/> No										
Eyelids: <input type="checkbox"/> Normal <input type="checkbox"/> Droopy		Tracking: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal												
Pulse and time 1. ___ / ___ 2. ___ / ___ 3. ___ / ___		HGN Lack of Smooth Pursuit Maximum Deviation Angle of Onset	Right Eye	Left Eye	<b>ONE LEG STAND</b>  L R <input type="checkbox"/> <input type="checkbox"/> Sways while balancing <input type="checkbox"/> <input type="checkbox"/> Uses arms to balance <input type="checkbox"/> <input type="checkbox"/> Hopping <input type="checkbox"/> <input type="checkbox"/> Puts foot down									
Romberg Balance 		Walk and turn test 	Convergence  Right eye Left eye Cannot keep balance _____ Starts too soon _____ Stops walking _____ Misses heel-toe _____ Steps off line _____ Raises arms _____ Actual steps taken _____ <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td>1st Nine</td> <td>2nd Nine</td> </tr> <tr> <td> </td> <td> </td> </tr> </table>			1st Nine	2nd Nine							
1st Nine	2nd Nine													
Internal clock estimated as 30 seconds	Describe Turn	Cannot do test (explain)		Type of footwear:										
<b>Draw lines to spots touched</b> 		<b>PUPIL SIZE</b>	<b>Room light</b> 2.5 - 5.0	<b>Darkness</b> 5.0 - 8.5	<b>Direct</b> 2.0 - 4.5									
		Left Eye												
		Right Eye												
		REBOUND DILATION <input type="checkbox"/> Yes <input type="checkbox"/> No		REACTION TO LIGHT:										
		<b>RIGHT ARM</b>		<b>LEFT ARM</b>										
														
Blood pressure	Temperature	Muscle tone: <input type="checkbox"/> Near Normal <input type="checkbox"/> Flaccid <input type="checkbox"/> Rigid		Comments:										
What drugs or medications have you been using?		How much?	Time of use?	Where were the drugs used? (Location)										
Date / Time of arrest:	Time DRE was notified:	Evaluation start time:	Evaluation completion time:	Precinct/Station:										
Officer's Signature:		DRE #	Reviewed/approved by / date:											
Opinion of Evaluator:		<input type="checkbox"/> Rule Out <input type="checkbox"/> Medical	<input type="checkbox"/> Alcohol <input type="checkbox"/> CNS Depressant	<input type="checkbox"/> CNS Stimulant <input type="checkbox"/> Hallucinogen	<input type="checkbox"/> Dissociative Anesthetic <input type="checkbox"/> Narcotic Analgesic									
				<input type="checkbox"/> Inhalant	<input type="checkbox"/> Cannabis									