

DRUG INFLUENCE EVALUATION

Evaluator		DRE #	Rolling Log #	Case #	
Recorder/Witness		Crash: <input type="checkbox"/> None <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property		Arresting Officer (Name, ID#):	
Arrestee's Name (Last, First, Middle)		Date of Birth	Sex	Race	Arresting Officer Agency:
Date Examined / Time /Location		Breath Results: Results:	Test Refused <input type="checkbox"/> 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"/> 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	
Tracking: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal		Eyelids: <input type="checkbox"/> Normal <input type="checkbox"/> Droopy			
Pulse and time 1. _____ / _____ 2. _____ / _____ 3. _____ / _____		HGN Lack of Smooth Pursuit Maximum Deviation Angle of Onset	Left Eye	Right Eye	Convergence Right Eye Left Eye
Modified Romberg Balance 		Walk and Turn Test Cannot keep balance _____ Starts too soon _____ Stops walking _____ Misses heel-toe _____ Steps off line _____ Raises arms _____ Actual steps taken _____		One Leg Stand L R L R 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	
Internal clock estimated as 30 seconds		Describe turn		Cannot do test (explain)	
Finger to Nose (Draw lines to spots touched) 		PUPIL SIZE		Room Light (2.5 - 5.0)	Darkness (5.0 - 8.5)
		Left Eye		Direct (2.0 - 4.5)	Nasal area:
		Right Eye			Oral cavity:
		Rebound Dilation: <input type="checkbox"/> Yes <input type="checkbox"/> No		Reaction to Light:	
		RIGHT ARM 		LEFT ARM 	
Blood pressure / Temperature		Muscle tone: <input type="checkbox"/> 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"/> No Impairment <input type="checkbox"/> Alcohol <input type="checkbox"/> CNS Stimulant <input type="checkbox"/> Dissociative Anesthetic <input type="checkbox"/> Inhalant <input type="checkbox"/> Medical <input type="checkbox"/> CNS Depressant <input type="checkbox"/> Hallucinogen <input type="checkbox"/> Narcotic Analgesic <input type="checkbox"/> Cannabis					