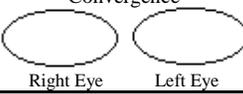
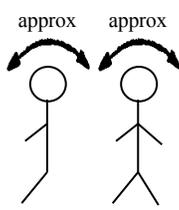
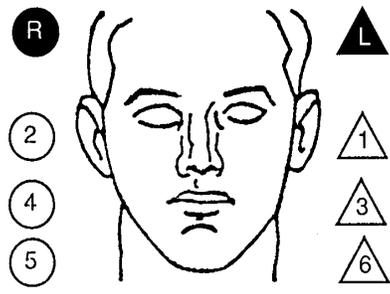
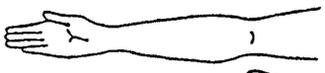
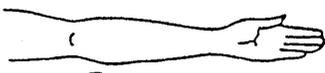
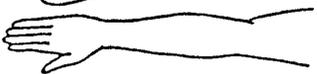
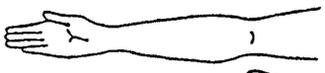
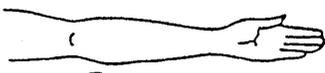
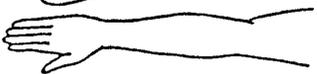
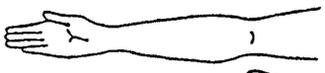
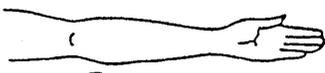
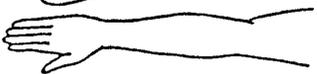


# DRUG INFLUENCE EVALUATION

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																																				
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 <input type="checkbox"/> Yes <input type="checkbox"/> No Given By:	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																																				
Pulse and time 1. ___ / ___ 2. ___ / ___ 3. ___ / ___		HGN	Left Eye	Right Eye																																				
		Lack of Smooth Pursuit	Convergence																																					
		Maximum Deviation																																						
		Angle of Onset	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 _____																																						
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">1st Nine</th> <th colspan="2">2nd Nine</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </table>			1st Nine		2nd Nine																																	
1st Nine		2nd Nine																																						
One Leg Stand																																								
Internal clock estimated as 30 seconds		Describe turn		Cannot do test (explain)																																				
Type of footwear:		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>PUPIL SIZE</th> <th>Room Light (2.5 - 5.0)</th> <th>Darkness (5.0 - 8.5)</th> <th>Direct (2.0 - 4.5)</th> </tr> <tr> <td>Left Eye</td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Right Eye</td> <td> </td> <td> </td> <td> </td> </tr> </table>			PUPIL SIZE	Room Light (2.5 - 5.0)	Darkness (5.0 - 8.5)	Direct (2.0 - 4.5)	Left Eye				Right Eye																											
PUPIL SIZE	Room Light (2.5 - 5.0)	Darkness (5.0 - 8.5)	Direct (2.0 - 4.5)																																					
Left Eye																																								
Right Eye																																								
Finger to Nose (Draw lines to spots touched)		Rebound Dilation: <input type="checkbox"/> Yes <input type="checkbox"/> No Pupillary Unrest: <input type="checkbox"/> Yes <input type="checkbox"/> No Reaction to Light:																																						
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th>RIGHT ARM</th> <th>LEFT ARM</th> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>			RIGHT ARM	LEFT ARM																																		
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"/> Not Impaired <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																																								