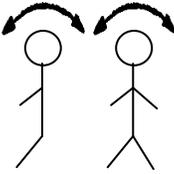
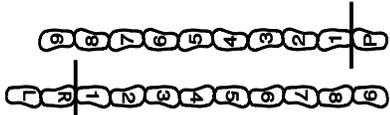
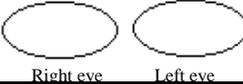
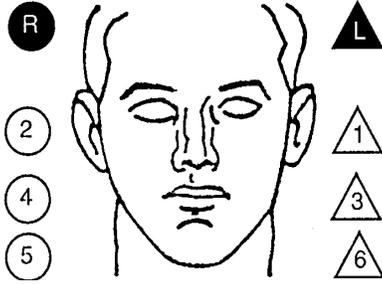
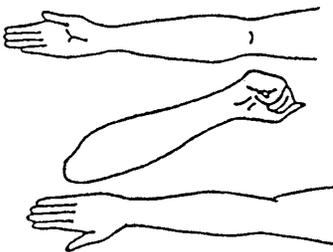
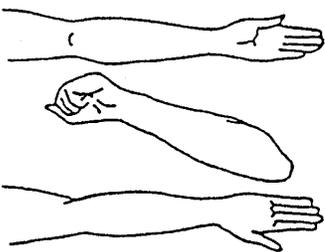


DRUG INFLUENCE EVALUATION

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#)		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"/>	
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 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		Tracking: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal	
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	
Pulse and time 1. ___ / ___ 2. ___ / ___ 3. ___ / ___		HGN Lack of Smooth Pursuit Maximum Deviation Angle of Onset		Right Eye		Left Eye	
Romberg Balance 		Walk and turn test 		Convergence 		ONE LEG STAND 	
Internal clock estimated as 30 seconds		Describe Turn		Cannot do test (explain)		Type of footwear:	
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		REBOUND DILATION <input type="checkbox"/> Yes <input type="checkbox"/> No		Oral cavity:	
Blood pressure		Temperature		RIGHT ARM 		LEFT ARM 	
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:	
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"/> Cannabin			