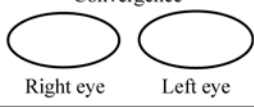

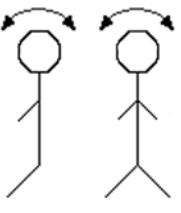
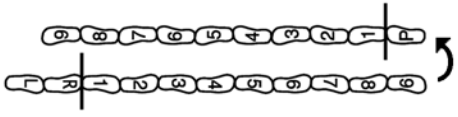
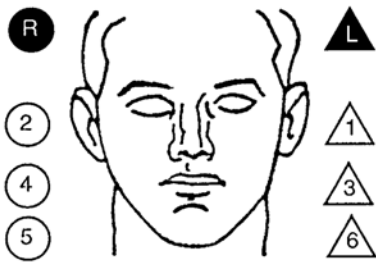

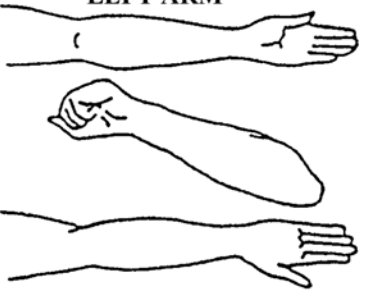


Evaluator		DRE No.		Rolling Log No.			
Recorder/Witness		Crash: <input type="checkbox"/> None <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property		Misc. No.		Arresting Officer's Agency	
Arrestee's Name (Last, First MI)		DOB		Sex		Race	
Date Examined/Time/Location		Breath Results: <input type="checkbox"/> Refused Instrument #		Chemical Test <input type="checkbox"/> Refused <input type="checkbox"/> Urine <input type="checkbox"/> Blood			
Miranda Warning Given: <input type="checkbox"/> Yes <input type="checkbox"/> No By:		What have you eaten today? When?		Have you been drinking? How much?		Time of last drink?	
Time now?		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:			
		Breath:		Face:			
Speech:		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 eye <input type="checkbox"/> Right eye		Tracking: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal	
Corrective lens: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft		Pupil size: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal, (explain)		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 Left eye Right eye		Vertical Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No		One Leg Stand	
		Lack of smooth pursuit		Convergence 			
		Maximum deviation		Right eye Left eye			
		Angle of onset					
Romberg Balance 		Walk and turn test 		Cannot keep balance: Starts too soon: _____ Stops Walking _____ Misses heel-toe _____ Steps off line _____ Raise arms _____ Actual # steps _____		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)		Type of footwear:	
Draw lines to spots touched 		Pupil Size		Room light		Darkness	
		Left					
		Right					
		Hippus <input type="checkbox"/> Yes <input type="checkbox"/> No		Rebound dilation <input type="checkbox"/> Yes <input type="checkbox"/> No		Reaction to light:	
		RIGHT ARM 		LEFT ARM 			
Blood pressure ___/___		Temperature ___°F					
Muscle tone: <input type="checkbox"/> Near normal <input type="checkbox"/> Flaccid <input type="checkbox"/> Rigid		Comments:					
What medication or drug have you been using? How much?		Time of use?		Where were the dugs used? (location)			
Member signature (Include rank)		ID #		Reviewed by:			
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"/> PCP <input type="checkbox"/> Narcotic Analgesic		<input type="checkbox"/> Inhalant <input type="checkbox"/> Cannabis			