

DRUG INFLUENCE EVALUATION

EVALUATOR		DRE#	ROLLING LOG#	EVALUATOR'S AGENCY	
RECORDER/WITNESS:		CRASH <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property <input type="checkbox"/> None		ARRESTING OFFICER'S AGENCY	
ARRESTEE'S NAME (LAST, FIRST, MIDDLE)		DOB	SEX	RACE	ARRESTING OFFICER (NAME, ID#)
DATE EXAMINED/TIME/LOCATION		BREATH RESULTS: _____ <input type="checkbox"/> REFUSED		CHEMICAL TEST	
		RESULTS _____ INSTRUMENT # _____		<input type="checkbox"/> Urine <input type="checkbox"/> Blood <input type="checkbox"/> Test or tests refused	
MIRANDA WARNING GIVEN: <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?
BY: _____					
TIME NOW?/ACTUAL	WHEN DID YOU LAST SLEEP? HOW LONG?		ARE YOU SICK OR INJURED?		ARE YOU DIABETIC OR EPILEPTIC?
			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
DO YOU TAKE INSULIN?		DO YOU HAVE ANY PHYSICAL DEFECT?		ARE YOU UNDER THE CARE OF A DOCTOR OR DENTIST?	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
ARE YOU TAKING ANY MEDICATION OR DRUGS?		ATTITUDE		COORDINATION	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
SPEECH:		BREATH ODOR:		FACE:	
CORRECTIVE LENSES:		EYES:		BLINDNESS:	
<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft <input type="checkbox"/> None		<input type="checkbox"/> Normal <input type="checkbox"/> Bloodshot <input type="checkbox"/> Watery <input type="checkbox"/> Reddened Conjunctiva		<input type="checkbox"/> None <input type="checkbox"/> Left <input type="checkbox"/> Right	
PUPIL SIZE: <input type="checkbox"/> Equal		VERTICAL NYSTAGMUS:		ABLE TO FOLLOW STIMULUS:	
<input type="checkbox"/> Unequal (explain)		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
PULSE & TIME:		HGN	LEFT EYE	RIGHT EYE	CONVERGENCE:
1. _____ / _____		LACK OF SMOOTH PURSUIT			
2. _____ / _____		MAX. DEVIATION			
3. _____ / _____		ANGLE OF ONSET			
ROMBERG BALANCE		WALK AND TURN TEST		CANNOT KEEP BALANCE _____	
APPROX.				STARTS TOO SOON _____	
APPROX.				STOPS WALKING <input type="checkbox"/> 1st NINE <input type="checkbox"/> 2nd NINE	
				MISSES HEEL-TOE <input type="checkbox"/>	
				STEPS OFF LINE <input type="checkbox"/>	
				RAISES ARMS <input type="checkbox"/>	
				ACTUAL STEPS TAKEN _____	
				<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 SEC.	DESCRIBE TURN		CANNOT DO TEST (EXPLAIN)	
TYPE OF FOOTWEAR:					
Draw lines to spots touched 		PUPIL SIZE	ROOM LIGHT	DARKNESS 5.0 - 8.5	DIRECT 2.0 - 4.5
		LEFT EYE			
		RIGHT EYE			
		REBOUND DILATION		REACTION TO LIGHT	
		<input type="checkbox"/> Yes <input type="checkbox"/> No			
		RIGHT ARM		LEFT ARM	
BLOOD PRESSURE		TEMP			
MUSCLE TONE: <input type="checkbox"/> NORMAL <input type="checkbox"/> FLACCID <input type="checkbox"/> RIGID					
COMMENTS:					
WHAT MEDICINE OR DRUG HAVE YOU BEEN USING?		HOW MUCH?	TIME OF USE?	WHERE WERE THE DRUGS USED? (Location)	
DATE/TIME OF ARREST	TIME OF 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"/> ALCOHOL	<input type="checkbox"/> CNS STIMULANT	<input type="checkbox"/> DISSOCIATIVE ANESTHETIC
		<input type="checkbox"/> MEDICAL	<input type="checkbox"/> CNS DEPRESSANT	<input type="checkbox"/> HALLUCINOGEN	<input type="checkbox"/> NARCOTIC ANALGESIC
				<input type="checkbox"/> INHALANT	<input type="checkbox"/> CANNABIS

STATE OF NEW JERSEY DRUG INFLUENCE EVALUATION CONTINUATION

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2. WITNESS

3. BREATH TEST

4. NOTIFICATION/ INTERVIEW ARRESTING OFFICER

5. INITIAL OBSERVATION

6. MEDICAL PROBLEMS

7. PSYCHOPHYSICAL

8. CLINICAL INDICATORS

9. SIGNS OF INGESTION

10. SUSPECT'S STATEMENT

11. OPINION

12. TOX SAMPLE

13. MISC.

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