

WASHINGTON STATE DRUG INFLUENCE EVALUATION

| | |
|--------------|-------------------|
| Case # _____ | Rolling Log # - - |
|--------------|-------------------|

Type of Evaluation: Traffic Other _____

Field Certification Mock Evaluation Recertification Instructor Observed

ADMINISTRATIVE DETAILS

| | | | | |
|---------------------------|-----------------|--|---|-------------------------|
| DRE Name | DRE Agency | Arrest Date | Time DRE Notified | Time Evaluation Started |
| DRE Number | | Arrest Time | | |
| Witness/Scribe | | Witness/Scribe is: <input type="checkbox"/> DRE <input type="checkbox"/> DRE Instructor | | County of Arrest |
| Miranda Warnings Given By | Time of Miranda | Location of Evaluation | Collision: <input type="checkbox"/> N/A <input type="checkbox"/> Injury <input type="checkbox"/> Fatality <input type="checkbox"/> Property | |

SUBJECT INFORMATION AND QUESTIONS

| | | | |
|--------------------------------------|---|-------------------------------------|---|
| Subject's Name (Last, First, MI) | DOB | Race | Driver's License Number and State |
| | Sex <input type="checkbox"/> M <input type="checkbox"/> F | | |
| What time is it? | What is the date? | What have you eaten today and when? | What have you had to drink today and when? |
| When did you last sleep? | Are you sick or injured? | | Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For how long? | | | If Yes, do you take Insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | Epileptic <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have any physical impairment? | Are you under the care of a doctor or dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name: | | What medications or drugs are you taking? |

Subject refused entire evaluation

1. BREATH TEST

| | | | |
|---------------------|-------------------|------|---|
| Breath Test Results | Instrument Number | Time | <input type="checkbox"/> BAC <input type="checkbox"/> PBT |
|---------------------|-------------------|------|---|

2. INTERVIEW OF ARRESTING OFFICER

| | | |
|------|--------|--|
| Name | Agency | <input type="checkbox"/> Arresting Officer is A.R.I.D.E. trained |
|------|--------|--|

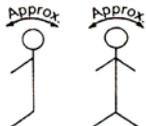
3. PRELIMINARY EXAMINATION AND 1st PULSE

| | | | | | | |
|--|---|---|---|--|--|---|
| First Pulse (beats per minute) at _____ hours. (Transfer to section 6) | | | | | | |
| Attitude | Coordination | Speech | Breath | Facial Color | | |
| Corrective Lenses <input type="checkbox"/> Hard Contacts <input type="checkbox"/> Soft Contacts <input type="checkbox"/> Glasses <input type="checkbox"/> None | Blindness <input type="checkbox"/> None <input type="checkbox"/> Left <input type="checkbox"/> Right | Eyes <input type="checkbox"/> Near Normal <input type="checkbox"/> Bloodshot <input type="checkbox"/> Watery | Eyelids <input type="checkbox"/> Normal <input type="checkbox"/> Droopy | Pupil Size <input type="checkbox"/> Equal <input type="checkbox"/> Unequal | Able to follow the stimulus? <input type="checkbox"/> Yes <input type="checkbox"/> No | Equal Tracking? <input type="checkbox"/> Yes <input type="checkbox"/> No |

4. EYE EXAMINATIONS

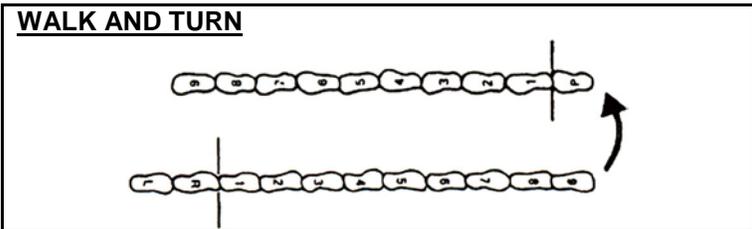
| HGN | Left | Right | Resting Nystagmus | Vertical Gaze Nystagmus | Notes and Observations |
|---|---|---|---|--|------------------------|
| Lack of Smooth Pursuit | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Distinct & Sustained Nystagmus at Maximum Deviation | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | Lack of Convergence <input type="checkbox"/> Yes <input type="checkbox"/> No Right Left | | |
| Angle of Onset Prior to 45 degrees | ° | ° | ○ | ○ | |

5. DIVIDED ATTENTION TESTS

| | | | |
|---|--|---|-------------------------------|
| Modified Romberg Balance  | Eyelid Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No | How many seconds? How did you estimate the time? | Notes and Observations |
| | seconds estimated as 30 seconds. | | |

Case #

Rolling Log # - -

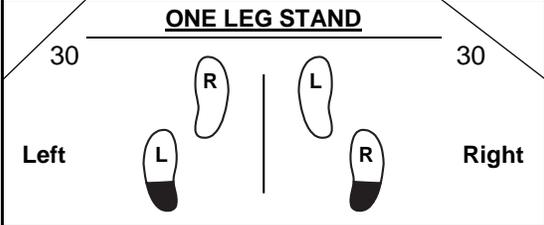


Notes and Observations

| | | |
|--------------------|--------------------------|--------------------------|
| Type of Footwear | | |
| Can't Keep Balance | <input type="checkbox"/> | |
| Starts Too Soon | <input type="checkbox"/> | |
| | Up | Back |
| Stops Walking | <input type="checkbox"/> | <input type="checkbox"/> |
| Misses Heel to Toe | <input type="checkbox"/> | <input type="checkbox"/> |
| Steps Off Line | <input type="checkbox"/> | <input type="checkbox"/> |
| Raises Arms | <input type="checkbox"/> | <input type="checkbox"/> |
| Actual Steps Taken | | |

Describe Turn

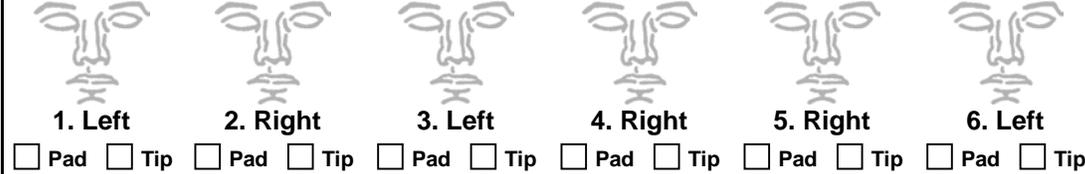
Cannot Do Test:



| Left | Right |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

Notes and Observations

FINGER TO NOSE Eyelid Tremors Muscle Tremors Swaying Brought Head Forward



Notes and Observations

6. VITAL SIGNS AND 2nd PULSE (BP: 120-140/70-90 mmHg) (PULSE: (60-90 bpm) (TEMP: 98.6 +/- 1 DEGREE)

| 3 PULSES | Pulse | Time |
|----------|-------|-------------------|
| First | | Taken from Step 3 |
| Second | | |
| Third | | Taken from Step 9 |

Blood Pressure / mmHg
Body Temperature ° F

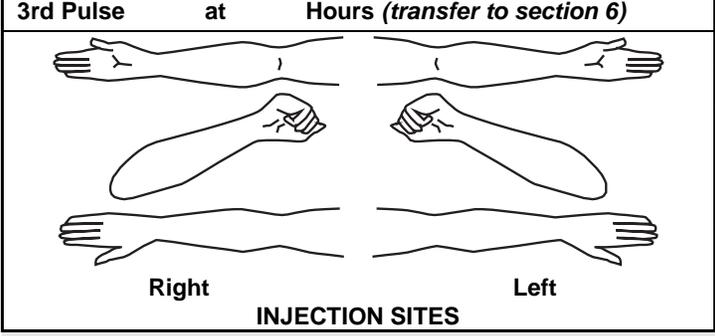
Notes and Observations

7. DARK ROOM CHECKS OF PUPIL SIZE AND INGESTION EXAMINATION UV LIGHT YES NO

| PUPIL SIZE | Room Light (2.5-5.0) | Darkness (5.0-8.5) | Direct (2.0-4.5) | Rebound Dilation <input type="checkbox"/> Yes <input type="checkbox"/> No | Nasal Area |
|------------|----------------------|--------------------|------------------|---|-------------|
| Left Eye | | | | Reaction to Light <input type="checkbox"/> Normal <input type="checkbox"/> Slow <input type="checkbox"/> Little/None | Oral Cavity |
| Right Eye | | | | Notes | |

8. CHECK FOR MUSCLE TONE MUSCLE TONE Near Normal Flaccid Rigid

9. CHECK FOR INJECTION SITES AND 3rd PULSE 10. INTERROGATION, STATEMENTS, AND OBSERVATIONS



| | | | |
|--|--|------------------|--------------|
| 3rd Pulse at Hours (transfer to section 6) | WHAT MEDICATIONS OR DRUGS HAVE YOU BEEN USING? | | |
| | TYPE OF DRUG? | HOW MUCH/DOSAGE? | TIME OF USE? |
| | | | |
| | | | |
| | Where were these drugs used? | | |
| | Notes, Statements, and Other Observations | | |

11. OPINION OF EVALUATOR

| | | | | |
|-------------------------------------|--|---------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> DEPRESSANT | <input type="checkbox"/> NARCOTIC ANALGESIC | <input type="checkbox"/> INHALANT | <input type="checkbox"/> CANNABIS | <input type="checkbox"/> NOT IMPAIRED |
| <input type="checkbox"/> STIMULANT | <input type="checkbox"/> DISSOCIATIVE ANESTHETIC | <input type="checkbox"/> HALLUCINOGEN | <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> MED RULE OUT |

12. TOXICOLOGICAL EXAM TIME SAMPLE OBTAINED

| | | |
|---|----------------|--|
| <input type="checkbox"/> BLOOD <input type="checkbox"/> BLOOD WARRANT OBTAINED <input type="checkbox"/> URINE <input type="checkbox"/> REFUSED <input type="checkbox"/> UNABLE TO OBTAIN <input type="checkbox"/> NOT REQUESTED | TIME COMPLETED | |
| <input type="checkbox"/> SUBJECT STOPPED PARTICIPATING DURING EVALUATION | STEP NUMBER | |
| EXAMINING DRE | BADGE # | REVIEWED BY DRE INSTRUCTOR (Signature, DRE Number, Date) |

Copies to: Arresting Officer Court Originating Agency Tox. Lab State Coordinator