

# WASHINGTON STATE DRUG INFLUENCE EVALUATION

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

<b>Type of Evaluation:</b> <input type="checkbox"/> Traffic <input type="checkbox"/> Training <input type="checkbox"/> Other _____
<b>If Training:</b> <input type="checkbox"/> Field Certification <input type="checkbox"/> Mock Evaluation <input type="checkbox"/> Recertification <input type="checkbox"/> 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
Do you have any physical impairment?		Are you under the care of a doctor or dentist?		Epileptic <input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, name:		What medications or drugs are you taking?

### 1. BREATH TEST

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

### 2. INTERVIEW OF ARRESTING OFFICER

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

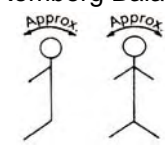
### 3. PRELIMINARY EXAMINATION

<b>First Pulse (beats per minute) at _____ hours. (Transfer to section 6)</b>						
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	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	
Distinct & Sustained Nystagmus at Maximum Deviation	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Lack of Convergence</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Right                      Left	
Angle of Onset Prior to 45 degrees	°	°	<div style="display: flex; justify-content: space-around; width: 100%;"> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; margin: 0 auto;"></div> <div style="border: 1px solid black; border-radius: 50%; width: 40px; height: 40px; margin: 0 auto;"></div> </div>	

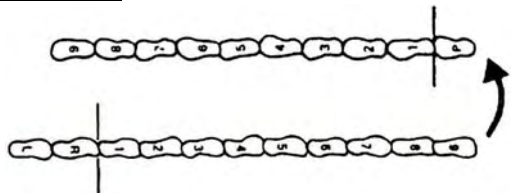
### 5. DIVIDED ATTENTION TESTS

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

Case #

Rolling Log # - -

**WALK AND TURN**



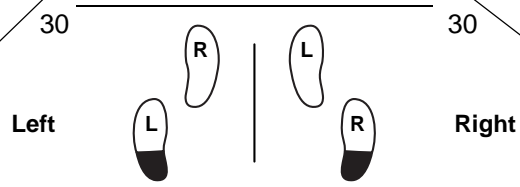
Notes and Observations

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:

**ONE LEG STAND**



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

Notes and Observations

Sways

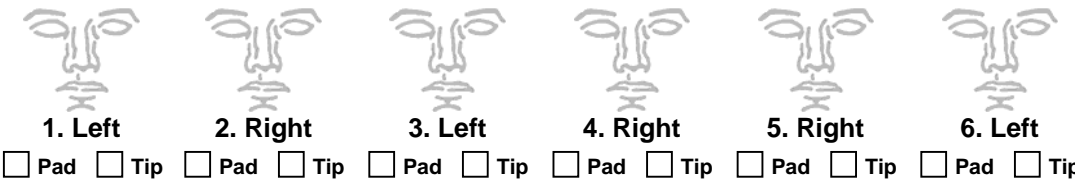
Uses Arms to Balance

Hops

Put Foot Down

**FINGER TO NOSE**

Eyelid Tremors  Muscle Tremors  Swaying  Brought Head Forward



Notes and Observations

**6. VITAL SIGNS AND 2nd PULSE** Normal – Heart rate 60-90 bpm – Blood Pressure 120-140/70-90 – Body Temperature 98.6°F +/- 1°

3 PULSES	Pulse	Time	Blood Pressure	Notes and Observations
First		Taken from Step 3	/ mmHg	
Second			Body Temperature	
Third		Taken from Step 9	° F	

**7. DARK ROOM CHECKS OF PUPIL SIZE AND INGESTION EXAMINATION**

PUPIL SIZE	Room Light 2.5 – 5.0 mm	Near Total Darkness 5.0 – 8.5 mm	Direct Light 2.0 – 4.5 mm	Rebound Dilation <input type="checkbox"/> Yes <input type="checkbox"/> No <i>A period of constriction and dilation with a change equal or greater than 2 mm</i>	Nasal Area
Left Eye				Pupillary Unrest <input type="checkbox"/> Yes <input type="checkbox"/> No <i>The continuous, irregular change in the size of the pupils</i>	Oral Cavity
Right Eye				Reaction to Light <input type="checkbox"/> Normal <input type="checkbox"/> Slow <input type="checkbox"/> Little/None	

**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**

<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	
EXAMINING DRE	BADGE #	REVIEWED BY DRE INSTRUCTOR (Signature, DRE Number, Date)

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