

COLORADO DRUG INFLUENCE EVALUATION FACESHEET

Rolling Log # - -

Case #

Type of Evaluation: Enforcement Field Certification/Recertification Other

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	Crash: <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? / Actual Time /	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?	

1. BREATH TEST

Breath Test Results	Instrument Number	Time	<input type="checkbox"/> BAC <input type="checkbox"/> PBT
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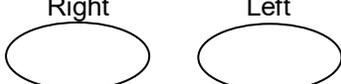
2. INTERVIEW OF ARRESTING OFFICER

Name	Agency	Agency Case#
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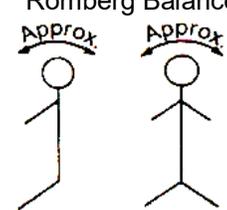
3. PRELIMINARY EXAMINATION

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"/> Colored	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 <input type="checkbox"/> Reddened Conjunctiva	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	Right	Left	Vertical Gaze Nystagmus	Notes and Observations
Lack of Smooth Pursuit	<input type="checkbox"/> Pres <input type="checkbox"/> No	<input type="checkbox"/> Pres <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Distinct & Sustained Nystagmus at Maximum Deviation	<input type="checkbox"/> Pres <input type="checkbox"/> No	<input type="checkbox"/> Pres <input type="checkbox"/> No	Lack of Convergence <input type="checkbox"/> Yes <input type="checkbox"/> No Right Left	
Angle of Onset	°	°		

5. DIVIDED ATTENTION TESTS

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.		

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WALK AND TURN Note:

Notes and Observations	Type of Footwear	
	Can't Keep Balance	<input type="checkbox"/>
	Starts Too Soon	<input type="checkbox"/>
		Up <input type="checkbox"/> Back <input type="checkbox"/>
	Stops Walking	<input type="checkbox"/>
	Misses Heel to Toe	<input type="checkbox"/>
	Steps Off Line	<input type="checkbox"/>
	Raises Arms	<input type="checkbox"/>
	Actual Steps Taken	
	Cannot Do Test:	<input type="checkbox"/>

Describe Turn

ONE LEG STAND

Left		Right	Notes and Observations
<input type="checkbox"/>	Sways	<input type="checkbox"/>	
<input type="checkbox"/>	Uses Arms to Balance	<input type="checkbox"/>	
<input type="checkbox"/>	Hops	<input type="checkbox"/>	
<input type="checkbox"/>	Puts Foot Down	<input type="checkbox"/>	

FINGER TO NOSE Eyelid Tremors Muscle Tremors Swaying Brought Head Forward

1. Left Pad Tip Pad Tip

2. Right Pad Tip Pad Tip

3. Left Pad Tip Pad Tip

4. Right Pad Tip Pad Tip

5. Right Pad Tip Pad Tip

6. Left Pad Tip Pad Tip

Notes and Observations

6. VITAL SIGNS AND 2nd PULSE

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 2.5-5.0mm	Near Total Darkness 5.0-8.5mm	Direct Light 2.0-4.5mm	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 and Observations	

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)

Right Left

INJECTION SITES

Note:

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"/> CNS DEPRESSANT	<input type="checkbox"/> HALLUCINOGEN	<input type="checkbox"/> NARCOTIC ANALGESIC	<input type="checkbox"/> CANNABIS	<input type="checkbox"/> MEDICAL
<input type="checkbox"/> CNS STIMULANT	<input type="checkbox"/> DISSOCIATIVE ANESTHETIC	<input type="checkbox"/> INHALANT	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> RULE OUT

12. TOXICOLOGICAL EXAM

<input type="checkbox"/> BLOOD	<input type="checkbox"/> URINE	<input type="checkbox"/> TOXTRAP	<input type="checkbox"/> SALIVA	<input type="checkbox"/> REFUSED	<input type="checkbox"/> UNABLE TO OBTAIN	<input type="checkbox"/> NOT REQUESTED	TIME COMPLETED
EXAMINING DRE	BADGE #	REVIEWED BY (Signature, DRE Number, Date)					

COLORADO DRUG INFLUENCE EVALUATION NARRATIVE

1. LOCATION:

2. WITNESSES:

3. BREATH ALCOHOL TEST:

4. NOTIFICATION AND INTERVIEW OF THE ARRESTING OFFICER:

5. INITIAL OBSERVATION OF SUSPECT:

6. MEDICAL PROBLEMS AND TREATMENT:

7. PSYCHOPHYSICAL TESTS:

8. CLINICAL INDICATORS:

9. SIGNS OF INGESTION:

10. SUSPECT'S STATEMENTS:

11. DRE'S OPINION:

12. TOXICOLOGICAL SAMPLE: