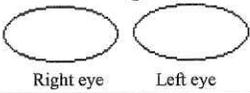
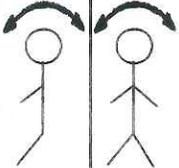
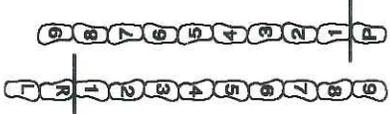
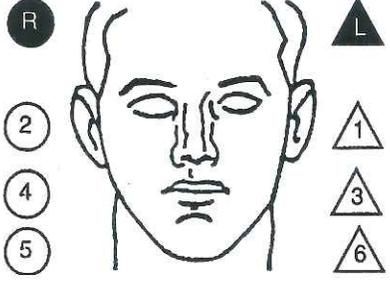
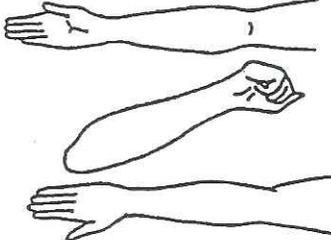
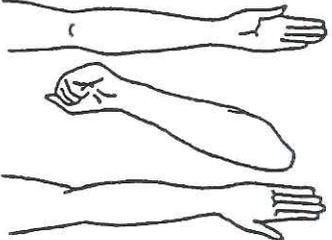


# Michigan Drug Influence Evaluation Form

Evaluator		DRE #	Rolling Log #	Evaluator's Agency	Case #
Recorder/Witness		Crash: <input type="checkbox"/> None <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property		Arresting Officer's Agency	
Arrestee's Name (Last, First, Middle)		Date of Birth	Sex	Race	Arresting Officer (Name, ID#)
Date Examined / Time / Location		Breath Results:	Test Refused <input type="checkbox"/>	Chemical Test: Urine <input type="checkbox"/> Blood <input type="checkbox"/>	
Miranda Warning Given		What have you eaten today? When?		What have you been drinking? How much? Time of last drink?	
Time now/ Actual		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:	
Speech:		Breath Odor:		Face:	
Corrective Lenses: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft		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 <input type="checkbox"/> Right	
Pupil Size: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal (explain)		Vertical Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No		Able to follow stimulus <input type="checkbox"/> Yes <input type="checkbox"/> No	
Pulse and time		HGN		/30 ONE LEG STAND /30	
1. _____ / _____		Right Eye		Convergence	
2. _____ / _____		Left Eye			
3. _____ / _____		Lack of Smooth Pursuit		Right eye      Left eye	
Romberg Balance		Maximum Deviation			
Approx.      Approx.		Angle of Onset			
		Walk and turn test			
					
Internal clock estimated as 30 seconds		Describe Turn		Cannot do test (explain)	
Finger to Nose (Draw lines to spots touched)		PUPIL SIZE		Nasal area:	
		Room light (2.5 - 5.0)		Oral cavity:	
		Darkness (5.0 - 8.5)			
		Direct (2.0 - 4.5)			
		REBOUND DILATION: <input type="checkbox"/> Yes <input type="checkbox"/> No		PUPILLARY UNREST: <input type="checkbox"/> Yes <input type="checkbox"/> No	
		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 drugs or medications have you been using?		How much?		Time of use? Where were the drugs used? (Location)	
Date / Time of arrest:		Time 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"/> Not Impaired <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"/> Dissociative Anesthetic <input type="checkbox"/> Narcotic Analgesic	
		<input type="checkbox"/> Inhalant <input type="checkbox"/> Cannabis			