

TEXAS DRUG INFLUENCE EVALUATION

Revised 02/2023

Evaluator	DRE #	Rolling Log #:	Case #:
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Recorder / Witnesses

Arresting Officer	Arresting Officer's Agency	Crash <input type="checkbox"/> None <input type="checkbox"/>
		Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property <input type="checkbox"/>

Arrestee's Name (Last, First, MI):	Age	Sex	Race	Breath Test: Results: _____ Instrument #: _____
				Refused <input type="checkbox"/>

Date Examined	Time	Location	Chemical Test <input type="checkbox"/> Refused <input type="checkbox"/>
			Oral Fluid <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/>

Miranda Warning Given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	What have you eaten today?	When?
By: _____		

What have you been drinking?	How much?	Time of last drink?
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Time now:	Actual	When did you last sleep?	How long?
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Are you sick or injured? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you diabetic or epileptic? Yes <input type="checkbox"/> No <input type="checkbox"/>
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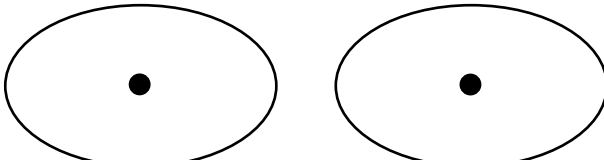
Do you take insulin? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have any physical defects? Yes <input type="checkbox"/> No <input type="checkbox"/>	Are you under the care of a doctor or dentist? Yes <input type="checkbox"/> No <input type="checkbox"/>
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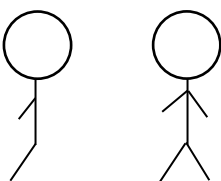
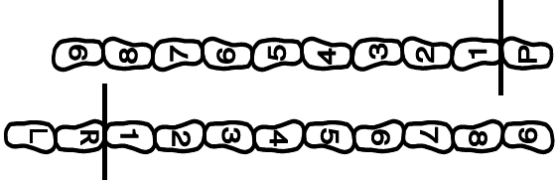
Are you taking any medication or drugs? Yes <input type="checkbox"/> No <input type="checkbox"/>	Attitude	Coordination
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Speech	Breath odor	Face
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First Pulse / Time /	Corrective Lenses None <input type="checkbox"/> <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft	Eyes <input type="checkbox"/> Normal <input type="checkbox"/> Bloodshot <input type="checkbox"/> Watery	Blindness <input type="checkbox"/> None <input type="checkbox"/> <input type="checkbox"/> Left <input type="checkbox"/> Right	Tracking <input type="checkbox"/> Equal <input type="checkbox"/> Unequal
Pupil size (explain) <input type="checkbox"/> Equal <input type="checkbox"/> Unequal	Resting Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No	Vertical Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No	Able to follow stimulus <input type="checkbox"/> Yes <input type="checkbox"/> No	Eyelids <input type="checkbox"/> Normal <input type="checkbox"/> Droopy



Preliminary Exam Notes

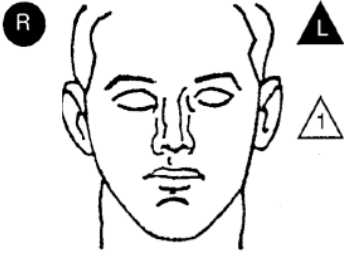
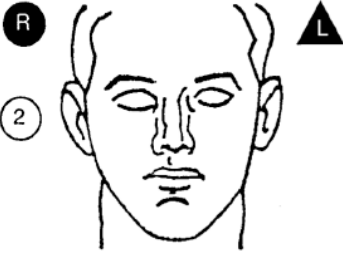
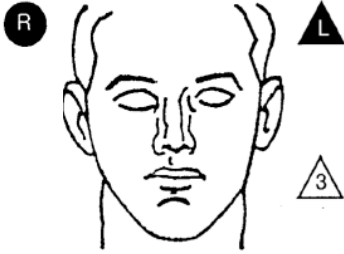
HGN	Left Eye	Right Eye	Convergence
Lack of Smooth Pursuit			<div style="display: flex; justify-content: space-around;"> <div style="text-align: center;">Right</div>  <div style="text-align: center;">Left</div> </div>
Maximum Deviation			
Angle of Onset			


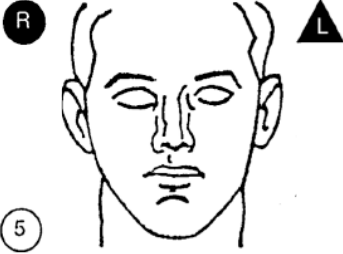
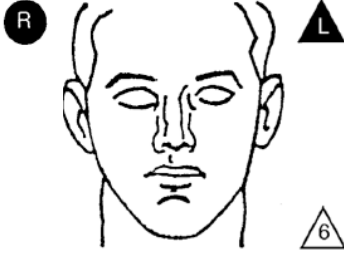
Modified Romberg Balance Test Approx.	Walk and Turn Test Approx.	Cannot keep balance																					
		Starts too soon																					
		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;"></td> <td style="width:25%;">1<sup>st</sup> Nine</td> <td style="width:25%;">2<sup>nd</sup> Nine</td> </tr> <tr> <td>Stops walking</td> <td></td> <td></td> </tr> <tr> <td>Misses heel-toe</td> <td></td> <td></td> </tr> <tr> <td>Steps off line</td> <td></td> <td></td> </tr> <tr> <td>Raises arms</td> <td></td> <td></td> </tr> <tr> <td>Actual steps taken</td> <td></td> <td></td> </tr> <tr> <td colspan="3">Type of footwear</td> </tr> </table>		1 <sup>st</sup> Nine	2 <sup>nd</sup> Nine	Stops walking			Misses heel-toe			Steps off line			Raises arms			Actual steps taken			Type of footwear		
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Describe turn	Cannot do test (explain)
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Time Estimation	Estimated as 30 seconds
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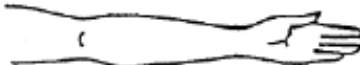




One Leg Stand-Left Leg / 30  	One Leg Stand-Right Leg / 30  	Sways while balancing Uses arms to balance Hopping Puts foot down
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(Draw lines to spots touched) <input type="checkbox"/> Sway <input type="checkbox"/> Pad <input type="checkbox"/> Searched <input type="checkbox"/> Opened eyes <input type="checkbox"/> Started with wrong hand <input type="checkbox"/> Told to put hand down 	(Draw lines to spots touched) <input type="checkbox"/> Sway <input type="checkbox"/> Pad <input type="checkbox"/> Searched <input type="checkbox"/> Opened eyes <input type="checkbox"/> Started with wrong hand <input type="checkbox"/> Told to put hand down 	(Draw lines to spots touched) <input type="checkbox"/> Sway <input type="checkbox"/> Pad <input type="checkbox"/> Searched <input type="checkbox"/> Opened eyes <input type="checkbox"/> Started with wrong hand <input type="checkbox"/> Told to put hand down 
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Second Pulse / Time	Blood Pressure	Body Temperature	Vital Signs Notes:
/	/ mmHg		

Pupil Size	Room light (2.5 - 5.0)	Darkness (5.0 - 8.5) UV Light used <input type="checkbox"/>	Direct (2.0 - 4.5)	Nasal Cavity
Left Eye				Oral Cavity
Right Eye				Rebound Dilation <input type="checkbox"/> Yes <input type="checkbox"/> No
				Reaction to Light

Third Pulse / Time	Muscle Tone <input type="checkbox"/> Normal <input type="checkbox"/> Flaccid <input type="checkbox"/> Rigid	Notes:	Right Arm	Left Arm
What drugs or medications have you been using?				
How much?				
				
			Time of Use	Where were the drugs used?

Date and time of arrest	Time DRE notified	Evaluation start time	Evaluation completion time	<input type="checkbox"/> Subject refused entire evaluation <input type="checkbox"/> Subject stopped participating during evaluation
DRE's Signature			Approved by & DRE number:	Date

Opinion of Evaluator:	<input type="checkbox"/> Not Impaired	<input type="checkbox"/> Alcohol	<input type="checkbox"/> CNS Stimulant	<input type="checkbox"/> Dissociative Anesthetic	<input type="checkbox"/> Inhalant
	<input type="checkbox"/> Medical	<input type="checkbox"/> CNS Depressant	<input type="checkbox"/> Hallucinogen	<input type="checkbox"/> Narcotic Analgesic	<input type="checkbox"/> Cannabis