
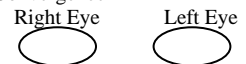
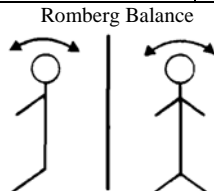
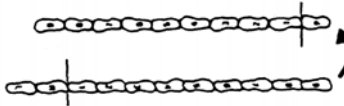
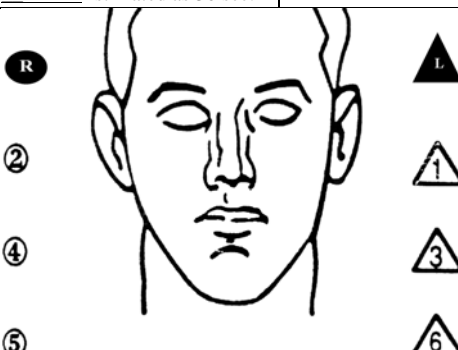
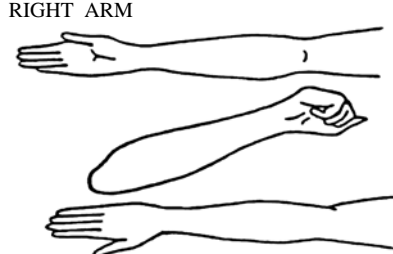
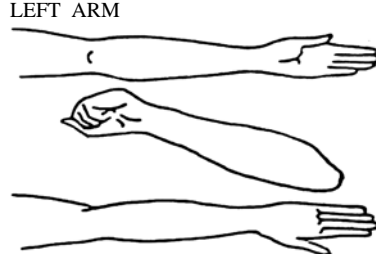


**Texas DRE Face Sheet**

Evaluator		DRE No.	Rolling log No.	Case Number	Evaluator's Agency	
Recorder/Witness		Crash: <input type="checkbox"/> None <input type="checkbox"/> Fatal <input type="checkbox"/> Injury <input type="checkbox"/> Property		Misc. No.	Arresting Officer's Agency	
Arrestee's Name: (Last, First, MI)		DOB:	Gender:	Race	Arresting Officer:	
Date Examined / Time / Location		Breath Results: <input type="checkbox"/> Refused Instrument #		Chemical Test: <input type="checkbox"/> Refused <input type="checkbox"/> Urine <input type="checkbox"/> Blood		
Miranda Warning Given: <input type="checkbox"/> Yes <input type="checkbox"/> No By:		What have you eaten today? When?		What have you been drinking? How much?	Time of last Drink?	
Time Now?	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 / 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		
		BREATH		FACE		
SPEECH		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 Eye <input type="checkbox"/> Right Eye	Tracking: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal	
CORRECTIVE LENS: <input type="checkbox"/> None <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts, if so <input type="checkbox"/> Hard <input type="checkbox"/> Soft		PUPIL SIZE: <input type="checkbox"/> Equal <input type="checkbox"/> Unequal (explain)		Able to follow stimulus: <input type="checkbox"/> Yes <input type="checkbox"/> No	Eyelids: <input type="checkbox"/> Normal <input type="checkbox"/> Droopy	
PULSE & TIME  1 / 2 / 3 /	HGN Lack of Smooth Pursuit	Right Eye	Left Eye	Vertical Nystagmus <input type="checkbox"/> Yes <input type="checkbox"/> No	ONE LEG STAND:   L R <input type="checkbox"/> <input type="checkbox"/> Sways while balancing <input type="checkbox"/> <input type="checkbox"/> Uses arms for balance <input type="checkbox"/> <input type="checkbox"/> Hopping <input type="checkbox"/> <input type="checkbox"/> Puts foot down	
	Maximum Deviation			Convergence Right Eye      Left Eye 		
	Angle of Onset					
Romberg Balance 		Walk And Turn Test 		Cannot keep balance _____ Starts too soon _____ 1 <sup>st</sup> Nine    2 <sup>nd</sup> Nine		
		Stops Walking				
		Miss Heel - Toe				
		Steps off line				
		Raises arms				
		Actual # Steps				
INTERNAL CLOCK Estimated as 30 sec.	Describe Turn		Cannot do test (explain)		Type of Footwear	
	PUPIL SIZE	Room light	Darkness	Direct	NASAL AREA	
	LEFT EYE				ORAL CAVITY	
	RIGHT EYE					
	HIPPUS <input type="checkbox"/> Yes <input type="checkbox"/> No	REBOUND DILATION <input type="checkbox"/> Yes <input type="checkbox"/> No		Reaction to Light		
	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 medicine or drug have you been using? How much?			Time of use?	Where were the drugs used? (location)		
Member Signature (Include rank)		ID #	Reviewed by:			

ATTACH PHOTOS OF FRESH PUNCTURE MARKS