

# Police Training Institute

## Alcohol / Drug Influence Report

Case Number: \_\_\_\_\_

ARRESTEE'S NAME: (Last, First, MI)	DOB:	AGE:	SEX:	RACE:	Arresting Officer:
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**Check Appropriate Conditions Observed (not during Field Sobriety Testing)**

<b>BALANCE</b>	<input type="checkbox"/> Falling	<input type="checkbox"/> Needs Support	<input type="checkbox"/> Wobbling	<input type="checkbox"/> Swaying	<input type="checkbox"/> Unsure	<input type="checkbox"/> Sure
<b>WALKING</b>	<input type="checkbox"/> Falling	<input type="checkbox"/> Staggering	<input type="checkbox"/> Stumbling	<input type="checkbox"/> Swaying	<input type="checkbox"/> Unsure	<input type="checkbox"/> Sure
<b>TURNING</b>	<input type="checkbox"/> Falling	<input type="checkbox"/> Staggering	<input type="checkbox"/> Hesitant	<input type="checkbox"/> Swaying	<input type="checkbox"/> Unsure	<input type="checkbox"/> Sure

Under 21  Yes  No      Where were field sobriety tests performed at: On scene  / other \_\_\_\_\_

### Horizontal Gaze Nystagmus

**Contacts**  Yes  No      **Equal Tracking**  Yes  No

\*Check Approximately the same Pupil Size\*

Total Clues
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Left      Right

Lake of Smooth Pursuit

Distinct/Sustained Nystagmus at Maximum Deviation

Onset of Nystagmus prior to 45 degrees


Vertical Nystagmus  Yes  No

Other: \_\_\_\_\_

### One Leg Stand

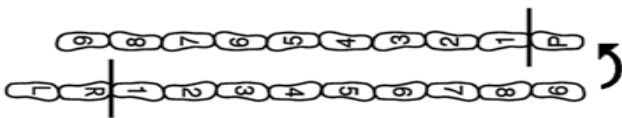
Total Clues
-------------



- |                          |  |
|--------------------------|--|
| 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"/> Hopes                 |
| <input type="checkbox"/> | <input type="checkbox"/> Puts foot Down        |

Comments: \_\_\_\_\_

### Walk and Turn



#### Instruction Stage:

Can't Keep Balance       Starts too soon       1<sup>st</sup> Nine      2<sup>nd</sup> Nine

#### Walking Stage:

Total Clues
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Stops Walking	
Misses Heel-to-Toe	
Steps Off Line	
Raises Arms	
Actual Steps Taken	

Improper Turn (Describe) \_\_\_\_\_

Cannot Perform Test – Explain: \_\_\_\_\_

Other: \_\_\_\_\_

### Finger to Nose

(Draw Lines to points touched)  
(Not an SFST test)



Comments: \_\_\_\_\_

#### Effects of Alcohol/Drugs or Combination:

Extreme     Obvious     Slight     None

Ability to Drive:  Unfit       Fit

Video Tape:  No     Yes / Tape # \_\_\_\_\_

Breath Test: Operator: \_\_\_\_\_

Observation Period Started \_\_\_\_\_

Time of Test \_\_\_\_\_ Results \_\_\_\_\_

**Chemical Test**

**Chemical Test Given:** Time Warning to Motorist Read: \_\_\_\_\_

None-Refused     Breath     Blood     Urine

Person Collecting Blood and/or Urine Sample:

Name \_\_\_\_\_ Time Blood Sample \_\_\_\_\_ hrs

Hospital \_\_\_\_\_ Time Urine Sample \_\_\_\_\_ hrs

Reporting Officer:	Badge No.	Date	Reviewing Supervisor:	Badge No.	Date
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<b>OBSERVATIONS</b>	<b>CLOTHES</b>	Describe: Type & Color	Hat or Cap _____ Jacket/Coat _____
			Shirt or Dress _____
			Pants or Skirt _____
			Shoes _____
		Condition: <input type="checkbox"/> Disorderly <input type="checkbox"/> Disarranged <input type="checkbox"/> Soiled <input type="checkbox"/> Mussed <input type="checkbox"/> Orderly <input type="checkbox"/> Other (Describe in Narrative)	
	<b>BREATH</b>	Odor of Alcoholic Beverage: <input type="checkbox"/> Strong <input type="checkbox"/> Moderate <input type="checkbox"/> Faint <input type="checkbox"/> None	
<b>ATTITUDE</b>	<input type="checkbox"/> Cooperative <input type="checkbox"/> Insulting <input type="checkbox"/> Talkative <input type="checkbox"/> Cocky <input type="checkbox"/> Sleepy <input type="checkbox"/> Profanity <input type="checkbox"/> Combative <input type="checkbox"/> Indifferent <input type="checkbox"/> Hilarious <input type="checkbox"/> Carefree <input type="checkbox"/> Excited <input type="checkbox"/> Polite		
<b>UNUSUAL ACTION</b>	<input type="checkbox"/> Hiccoughing <input type="checkbox"/> Belching <input type="checkbox"/> Vomiting <input type="checkbox"/> Fighting <input type="checkbox"/> Crying <input type="checkbox"/> Laughing		
<b>SPEECH</b>	<input type="checkbox"/> Not Understandable <input type="checkbox"/> Thick Tongued <input type="checkbox"/> Slurred <input type="checkbox"/> Confused <input type="checkbox"/> Mumbled <input type="checkbox"/> Stuttered <input type="checkbox"/> Accent <input type="checkbox"/> Fair <input type="checkbox"/> Good		
Indicate any other unusual actions or statements:			
<b>INTERVIEW</b>	Interview:   Miranda Warning Given: <input type="checkbox"/> No <input type="checkbox"/> Yes   -   Time: _____ Date _____		
	1. You have the right to remain silent. You do not have to talk to me unless you want to do so. 2. Anything you say can and will be used as evidence against you in court. 3. You are entitled to a lawyer and to have him present now or anytime during questioning. 4. If you cannot afford a lawyer, one will be appointed for you without cost.		
	Do you understand your rights <input type="checkbox"/> No <input type="checkbox"/> Yes     Knowing these rights are you willing to talk to me <input type="checkbox"/> No <input type="checkbox"/> Yes		
	Interview Location _____		
	Witnesses to Interview _____		
	What City are you in? _____		When did you last eat? _____
	What time is it now? _____		What did you eat? _____
	What is the date? _____		_____
	What day of the week is it? _____		Have you been drinking? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you ill? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what? _____
If yes, what is wrong? _____		How much? _____	
_____		Where have you been drinking? _____	
Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No		What time did you start drinking? _____	
If yes, last dose? _____		What time did you stop drinking? _____	
Have you been injured lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		Prior to the traffic stop, what have you been doing the last 3 hours? _____	
If yes, describe injury: _____		_____	
_____		_____	
Have you seen a Doctor or Dentist lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		Where you operating a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, who & what for: _____		What street were you on? _____	
_____		_____	
Have you taken medication in the last 6 hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		Direction of travel? _____	
If yes, what? _____		Are you under the influence of alcohol and or drugs now? <input type="checkbox"/> Yes <input type="checkbox"/> No	