

Driver's Name: _____ Approx. Wt.: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Minors in Vehicle: <input type="checkbox"/> Yes <input type="checkbox"/> No Blood / Breath Results: 0. / 0. Vehicle Crash: <input type="checkbox"/> Yes <input type="checkbox"/> No Injuries: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____ Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm	<h2 style="margin:0;">Driving While Impaired Report (DWIR)</h2> <p style="margin:0;">Department of Health and Human Services, Forensic Tests for Alcohol Branch</p>	Agency: _____ Officer's Name: _____ Case No.: _____ DRE Officer: _____ City / County: _____ Street / Highway: _____
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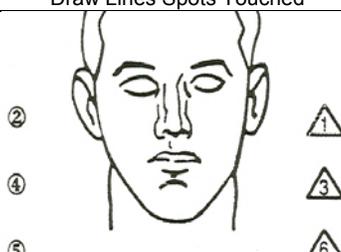
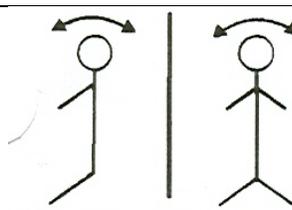
Phase I	Initial Observations: What drew your attention to the vehicle (wide turns, weaving, violations of law, etc.). Unusual driver's actions, blank stare, etc.: Observation of Stop: Describe vehicle maneuvers during the stop, delays in stopping, unusual manner of parking, etc.:
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Phase II	General Observation: Observation of driver, condition of clothing, attitude, speech, ability to follow instruction, etc.: Breath: Describe the odor of alcohol on driver's breath: Statements: Any statement made by the driver from time of stop to arrest: Observation Prior to Arrest: Describe any difficulty with motor skills, retrieving drivers license, getting out of vehicle, walking, standing, etc.: Odors: Describe any significant odors other than alcohol:
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Phase III

Psychophysical Tests	Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm
Location Performed: _____	

Horizontal Gaze Nystagmus (HGN)	Walk and Turn Test													
<input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses Remove Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No Tracking Equal? <input type="checkbox"/> Yes <input type="checkbox"/> No Able to Follow Stimulus? <input type="checkbox"/> Yes <input type="checkbox"/> No Lack of Smooth Pursuit Maximum Deviation Onset Prior 45° Vertical Nystagmus? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	<input type="checkbox"/> Cannot Keep Balance <input type="checkbox"/> Starts Too Soon <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th>First 9 Steps</th> <th>Second 9 steps</th> </tr> <tr> <td>Stops Walking</td> <td></td> </tr> <tr> <td>Misses Heel to Toe</td> <td></td> </tr> <tr> <td>Steps Off Line</td> <td></td> </tr> <tr> <td>Uses Arms To Balance</td> <td></td> </tr> <tr> <td>Actual Steps Taken</td> <td></td> </tr> </table> Improper Turn (Describe): _____ Cannot Do Test (Explain): _____	First 9 Steps	Second 9 steps	Stops Walking		Misses Heel to Toe		Steps Off Line		Uses Arms To Balance		Actual Steps Taken		Walk and Turn Test 
First 9 Steps	Second 9 steps													
Stops Walking														
Misses Heel to Toe														
Steps Off Line														
Uses Arms To Balance														
Actual Steps Taken														

One Leg Stand	Finger to Nose Test	Romberg Balance		
 Sways While Balancing: <input type="checkbox"/> L <input type="checkbox"/> R Uses Arms for Balance: <input type="checkbox"/> L <input type="checkbox"/> R Hopping: <input type="checkbox"/> L <input type="checkbox"/> R Puts Foot Down: <input type="checkbox"/> L <input type="checkbox"/> R Type of Footwear: _____	Draw Lines Spots Touched 	 <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Internal Clock</td> </tr> <tr> <td style="text-align: center;">Estimated _____ as 30 Seconds</td> </tr> </table>	Internal Clock	Estimated _____ as 30 Seconds
Internal Clock				
Estimated _____ as 30 Seconds				

Alcohol Screening Test Device (If test result is 0.08 or greater, wait 5 minutes and administer an additional test)			
Make / Model	Serial #		
Test 1	Test 2		
Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm Result: 0.	Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm Result: 0.		

Miranda Rights

Driver's Name: _____

Miranda Rights Advised: <input type="checkbox"/> Yes <input type="checkbox"/> No	Miranda Rights Waived: <input type="checkbox"/> Yes <input type="checkbox"/> No
Location: _____	Date: _____ Time: _____ <input type="checkbox"/> am <input type="checkbox"/> pm

Questionnaire

Were you operating a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No		Were there any mechanical problems with that vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Describe: _____			
Where were you going? _____		Where were you coming from? _____	
What street or highway were you on? _____		What city are you in now? _____	
Without looking at a watch, what time is it now? _____		<input type="checkbox"/> am <input type="checkbox"/> pm	What is the date? _____
What is the day of the week? _____		Actual Time _____	Actual Date _____ Actual Day _____
When did you last eat? _____		<input type="checkbox"/> am <input type="checkbox"/> pm	
What did you eat? _____			
What time did you begin drinking? _____		<input type="checkbox"/> am <input type="checkbox"/> pm	Last drink? _____ <input type="checkbox"/> am <input type="checkbox"/> pm
What did you drink? _____			
How many? _____	What size? _____	Where? _____	
Have you smoked Marijuana lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		Used any other drug? <input type="checkbox"/> Yes <input type="checkbox"/> No	
On a scale of 0 to 10, with 0 being completely sober and 10 being completely drunk, where do you fit? (Check one.)			
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	
In your opinion, should you have been operating a vehicle? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any physical defects? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what? _____	
Are you sick? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what's wrong? _____	
Do you limp? <input type="checkbox"/> Yes <input type="checkbox"/> No		Why do you limp? _____	
Have you been injured lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what type of injury? _____	
Were you involved in a crash today? <input type="checkbox"/> Yes <input type="checkbox"/> No		When did the crash occur? _____ <input type="checkbox"/> am <input type="checkbox"/> pm	
Did you get a bump on your head? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you had any alcoholic beverage(s) since the crash? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, what? _____		How many? _____	
When? _____		Where? _____	
Have you seen a doctor or dentist lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, who? _____	
What for? _____ When? _____			
When did you last go to sleep? _____		How much sleep did you have? _____	
Are you wearing false teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you wearing oral jewelry? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Do you have a glass eye? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you taking medication(s) of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No		How much taken? _____	
If so, what kind? _____			
Last dose? _____		<input type="checkbox"/> am <input type="checkbox"/> pm	
Do you have epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you take insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so last dose? _____	
Have you had any injections of any other drugs lately? <input type="checkbox"/> Yes <input type="checkbox"/> No		If so, what for? _____	
What kind of drug? _____		Last dose? _____ <input type="checkbox"/> am <input type="checkbox"/> pm	

Passengers

	Name	Age	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Witnesses

	Name	Address	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Notes