ALCOHOL/DRUG INFLUENCE REPORT

Wisconsin Department of Transportation

SP4005 4/2011

Print

Name	Citation #	Police # *(agency case #)*	
Street Address	Arrest Date	Arrest Time	Arrested By
City State ZIP Code	Incident Date	Incident Time	Department
Names of Other Occupants in Vehicle	Condition of Other Occupants		
Describe Clothing and Footwear *(type and condition)*	Breath, Odor of Alcohol or Drug *(none, light, moderate, strong)*		
Attitude *(cooperative, uncooperative, combative)*	Speech		
Signs of Complaints of Illness or Injury	What first led you to suspect alcohol or drug influence		
Opinion: Is the subject under the influence of intoxicants? ☐ Yes ☐ No	Opinion: Is the subject's ability to operate a motor vehicle impaired? ☐ Yes ☐ No		
Witness(es)			

Pre-Interrogation Warning: Before we ask you any questions, you must understand your rights. You have the right to remain silent. Anything you say can and will be used against you in court. You have the right to talk to a lawyer before questioning and to have the lawyer with you during questioning. If you cannot afford a lawyer and want one, a lawyer will be appointed for you without charge prior to any questioning. If you decide to start answering questions at this time, you can stop anytime during the questioning.

Waiver of Rights: I have read, or have had read to me this statement of my rights. I understand what my rights are. I am willing to answer questions at this time. I do not want a lawyer at this time. I understand and know what I am doing.

Date	Signature
Time	Witness
Notes	

Were you operating a motor vehicle? ☐ Yes ☐ No			
What street or highway were you on:			
Where were you going?		Where were you coming from?	
What is today's date?		What is the time?	
When did you last sleep?	How much sleep did you have?	Is that your normal amount? ☐ Yes ☐ No	
Are you under a doctor's care? ☐ Yes ☐ No	For what?		
Have you taken any prescription medication/drugs in the last 24 hours? ☐ Yes ☐ No	For what?		Time/date of last use
Have you been to a dentist in the past 24 hours? ☐ Yes ☐ No	What time?	What kind of dental care did you receive?	
Do you have GERD? ☐ Yes ☐ No	Diabetes? ☐ Yes ☐ No	Are you taking insulin? ☐ Yes ☐ No	Time/date of last dose
Were you injured recently? ☐ Yes ☐ No	If yes, please describe:		
Do you have any physical defects? ☐ Yes ☐ No	If yes, please describe:		
Have you been drinking? ☐ Yes ☐ No	How much?	Time started	Time stopped
What have you been drinking?		Where were you drinking?	With whom were you drinking?
Have you been using drugs?? ☐ Yes ☐ No		What type?	
From the time you last operated a motor vehicle, have you been drinking or using drugs? ☐ Yes ☐ No		What type?	Are you under the influence of alcohol or drugs at this time? ☐ Yes ☐ No
Were you involved in a crash today? ☐ Yes ☐ No	Have you been drinking or using drugs since then? ☐ Yes ☐ No	What and how much?	