

Douglas County Reasonable Suspicion

ORS-46

Documentation Form

Reasonable Cause/Reasonable Suspicion Testing Form

Please record the following information to document your reasonable cause/reasonable suspicion test determination.

Employee's Name: _____ Employee's ID/SSN: _____

Job Title: _____

Location of Incident: _____ Date: _____ Time Observed: _____

Supervisor's Name & Signature: _____

Concurring Supervisor's Name & Signature: _____

Observations (Please check all that apply, and include descriptions of any *changes* in behavior.)

Appearance:

<input type="checkbox"/> Normal	<input type="checkbox"/> Tremors/ Twitches	<input type="checkbox"/> Flushed or Pale	<input type="checkbox"/> Dilated Pupils
<input type="checkbox"/> Sleepy	<input type="checkbox"/> Sores/ Puncture Marks	<input type="checkbox"/> Heavy Eyelids	<input type="checkbox"/> Bloodshot eyes
<input type="checkbox"/> Disheveled	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Cleanliness	<input type="checkbox"/> Other (explain below)

Description/Notes: _____

Behavior/ Demeanor:

<input type="checkbox"/> Nervous	<input type="checkbox"/> Erratic	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Lethargic
<input type="checkbox"/> Irritable	<input type="checkbox"/> Paranoid	<input type="checkbox"/> Verbally/Physically Abusive	<input type="checkbox"/> Highly Excited
<input type="checkbox"/> Confusion/Inattentive	<input type="checkbox"/> Combative	<input type="checkbox"/> Fatigue/ Sleeping/ Drowsiness	<input type="checkbox"/> Other (explain below)

Description/Notes: _____

Motor Skills:

<input type="checkbox"/> Normal	<input type="checkbox"/> Swaying	<input type="checkbox"/> Falling	<input type="checkbox"/> Unbalanced	<input type="checkbox"/> Other (explain below)
<input type="checkbox"/> Unsteady	<input type="checkbox"/> Lack of Coordination	<input type="checkbox"/> Fidgety	<input type="checkbox"/> Stumbling	

Description/Notes: _____

Speech:

<input type="checkbox"/> Normal	<input type="checkbox"/> Slurred	<input type="checkbox"/> Loud	<input type="checkbox"/> Other (explain below)
<input type="checkbox"/> Incoherent	<input type="checkbox"/> Exaggerated	<input type="checkbox"/> Talking Excessively	

Description/Notes: _____

Odor:

<input type="checkbox"/> Normal	<input type="checkbox"/> Smell of Alcohol	<input type="checkbox"/> Excessive Cologne
<input type="checkbox"/> Body Odor	<input type="checkbox"/> Smell of Marijuana	<input type="checkbox"/> Other (explain below)

Description/Notes: _____

Test Conducted: Yes No

Comments: _____