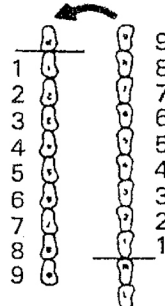


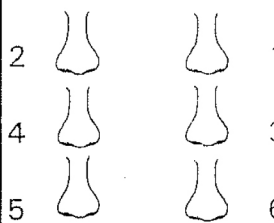
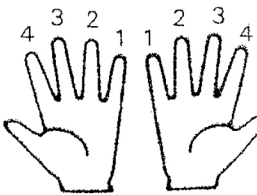


STANDARD FIELD SOBRIETY TEST GUIDELINES

| # 1 Horizontal Gaze Nystagmus | # 2 Walk & Turn | # 3 One Leg Stand (30 seconds) | # 4 Rhombberg-Modified (30 seconds) | # 5 Finger to Nose | # 6 Finger Count |
|--|---|--|--|--|--|
| <p><u>When I tell you:</u></p> <p>a. Remove glasses/note contacts b. Head still c. Follow stimulus with eyes</p> | <p><u>When I tell you:</u></p> <p>a. Right foot in front of left foot b. Hands at sides c. Don't move d. <u>Understand</u></p> <p><u>When I tell you:</u></p> <p>a. 9 heel/toe steps b. Count out loud, look at feet c. Turn as shown d. Do not stop until completed e. <u>Understand</u></p> | <p><u>When I tell you:</u></p> <p>a. Feet together b. Arms at sides c. Lift leg six inches d. Count 1001, 1002, etc. until told to stop e. <u>Understand</u></p> | <p><u>When I tell you:</u></p> <p>a. Feet together b. Arms at sides c. Eyes closed, head back d. <u>Understand</u></p> | <p><u>When I tell you:</u></p> <p>a. Feet together b. Arms at sides c. Point index finger d. Eyes closed, head back e. Tip of finger to tip of nose then return f. <u>Understand</u></p> | <p><u>When I tell you:</u></p> <p>a. Feet together b. Arms at sides c. Count out loud d. Proper finger to thumb e. Exactly 1-2-3-4-4-3-2-1 f. <u>Understand</u></p> |
| <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Left eye does not follow smoothly <input type="checkbox"/> Distinct nystagmus at maximum deviation of the left eye <input type="checkbox"/> Left eye onset before 45° <input type="checkbox"/> Right eye does not follow smoothly <input type="checkbox"/> Distinct nystagmus at maximum deviation of the right eye <input type="checkbox"/> Right eye onset before 45° <input type="checkbox"/> Vertical nystagmus</p> <p>NAME _____</p> <p>ID NUMBER _____</p> <p>A certified HGN Technician</p> | <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Cannot keep balance while listening to instructions <input type="checkbox"/> Starts before instructions are finished <input type="checkbox"/> Stops while walking <input type="checkbox"/> Does not touch heel to toe <input type="checkbox"/> Steps off line <input type="checkbox"/> Raises arms <input type="checkbox"/> Loses balance while turning <input type="checkbox"/> Incorrect number of steps</p>  <p style="text-align: center;">Shoes/Type</p> | <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Sways while balancing <input type="checkbox"/> Uses arms to balance <input type="checkbox"/> Hopping <input type="checkbox"/> Puts foot down</p>  <p style="text-align: center;"><u>SWAY</u></p> <p>Back to front Side to side</p> <p><input type="checkbox"/> 1-2" <input type="checkbox"/> 1-2" <input type="checkbox"/> 3-4" <input type="checkbox"/> 3-4" <input type="checkbox"/> 5"+ <input type="checkbox"/> 5"+</p> | <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Required additional instruction during testing <input type="checkbox"/> Opened eyes during testing <input type="checkbox"/> Failed to keep heels together throughout <input type="checkbox"/> Failed to keep head back <input type="checkbox"/> Swayed front to back or side to side (Record below) <input type="checkbox"/> Error in alphabet (Record below) <input type="checkbox"/> Error in backward count (Record below)</p>  <p style="text-align: center;"><u>SWAY</u></p> <p>Back to front Side to side</p> <p><input type="checkbox"/> 1-2" <input type="checkbox"/> 1-2" <input type="checkbox"/> 3-4" <input type="checkbox"/> 3-4" <input type="checkbox"/> 5"+ <input type="checkbox"/> 5"+</p> <p>Alphabet: A B C D E F G H I J K L M N O P Q R S T U V W X Y Z Count: _____</p> | <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Required additional instruction during testing <input type="checkbox"/> Opened eyes during testing <input type="checkbox"/> Failed to keep heels together throughout <input type="checkbox"/> Failed to keep head tilted back <input type="checkbox"/> Used hand other than the one designated <input type="checkbox"/> Missed nose with fingertip (Record miss locations below) <input type="checkbox"/> Touched nose with other than fingertip <input type="checkbox"/> Swayed front to back or side to side</p> <p>RIGHT LEFT</p>  <p>2 1 4 3 5 6</p> <p style="text-align: center;">Mark Positions Touched</p> | <p><u>OBSERVATION</u></p> <p><input type="checkbox"/> Required additional instruction during testing <input type="checkbox"/> Used hand other than the one designated <input type="checkbox"/> Missed touching all the proper fingers (Record below) <input type="checkbox"/> Counted incorrectly (Record below)</p>  |
| <p>ESST COMMENTS</p> <hr/> | | | | | |

TYPE OF SURFACE USED FOR FIELD TEST

- LEVEL UNEVEN CEMENT ASPHALT DRY OTHER: _____
 DIRT GRAVEL STREET SIDEWALK WET

TRAFFIC CONDITIONS

- LIGHT MODERATE HEAVY

WEATHER CONDITIONS

- CLEAR WINDY RAIN OTHER