

Checklist for Evaluation of Suspected Impairment

Suggested Checklist for Evaluation of Suspected Impairment
Prepared by the NCBON Workplace Taskforce (2005)

Employee Name: _____ Department: _____

Shift: _____ Time: _____ Date: _____

Brief Synopsis of Event:

Check witnessed events:

<input type="checkbox"/> Acted in manner endangering safety or self or others	<input type="checkbox"/> Had slurred or rambling speech
<input type="checkbox"/> Was unusually and markedly irritable, resentful, or over reactive	<input type="checkbox"/> Showed unsteady gait, loss of balance or other obvious coordination problem
<input type="checkbox"/> Acted or talked in irrational manner	<input type="checkbox"/> Pupillary size change and/or bloodshot eyes
<input type="checkbox"/> Showed marked swings of emotion or mood	<input type="checkbox"/> Change in handwriting
<input type="checkbox"/> Appeared unusually sleepy or fell asleep	<input type="checkbox"/> Unintelligible documentation
<input type="checkbox"/> Acted in an unusually loud, aggressive, or argumentative manner	<input type="checkbox"/> Suddenly had difficulty handling complex assignments and/or remembering work-related directions
<input type="checkbox"/> Threatened violence	<input type="checkbox"/> Odor or alcohol on breath
<input type="checkbox"/> Appeared unusually withdrawn	<input type="checkbox"/> Seen accessing automated dispensing systems when off duty
<input type="checkbox"/> Unusually talkative and/or boisterous	<input type="checkbox"/> Observed ingesting or injecting unknown substance
<input type="checkbox"/> Unusually restless or pacing around	<input type="checkbox"/> Disappeared from work station frequently or for long periods of time without adequate explanation
<input type="checkbox"/> Showed tremors or "shakes"	<input type="checkbox"/> Disappears at work, takes break or visits restroom after accessing controlled substances
<input type="checkbox"/> Appeared confused or disoriented	<input type="checkbox"/> Other:
<input type="checkbox"/> Fainted, passed out, had a sudden illness at work, or had convulsive seizure	

Details of above checked events:

Explanation/comments made by employee:

Obtained Employee's Written Statement: Yes No

Request made for routine drug screening: Yes No

*The following drugs are typically not covered in a routine screening panel. From the list provided check those **additional drugs** for which the employee should be tested.*

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Midazolam (Versed ®)
<input type="checkbox"/> Butorphanol (Stadol ®)	<input type="checkbox"/> Nalbuphine (Nubain ®)
<input type="checkbox"/> Dilaudid	<input type="checkbox"/> Oxycodone (e.g. Roxicodone ®, Oxydose ®, Oxycontin ®, Percocet ®, Tylox ®, Oxyprofen ®)
<input type="checkbox"/> Fentanyl (e.g. Duragesic ®, Sublimase ®)	<input type="checkbox"/> Promethazine (e.g. Phenergan ®)
<input type="checkbox"/> Hydrocodone (e.g. Hycodan ®, Vicoprofen ®, Vicodin ®, Lorcet ®, Lortab ®, Tussionex ®)	<input type="checkbox"/> Propofol (Diprivan ®)
<input type="checkbox"/> Ketamine (Ketolar ®)	<input type="checkbox"/> Propoxyphene (e.g. Darvon ®, Darvocet ®)
<input type="checkbox"/> Meperidine (Demerol ®)	<input type="checkbox"/> Tramadol (Ultram ®, Ultracet ®)
<input type="checkbox"/> Methadone (eg Methadose ®, Dolophine ®)	

Other:

Person and/or laboratory contacted for drug screening:

Date: _____ Time: _____ In Person: Telephone:

Signature of Supervisor: _____ Date: _____ Time: _____

Signature of Witness: _____ Date: _____ Time: _____