Superior Court

Recovery Court Program

Referral

All Fields are Required - Form will not be Processed if Incomplete

Referral Date: _____

Name of Defendant: _____ also known as _____

Date of Birth: _____

Referring Source or Attorney: _____

Source or Attorney: Telephone Number _____ Facsimile Number _____

Pending Case Number and Type of Charge:	Court Date:	For:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Location of Defendant for Contact:

Adult Correctional Institutions ☐ Division: _____ Bail Status: _____
Other: _____

Street Address: _____

City or Town: _____ State: _____

Telephone Number: _____

Alternate Telephone Contact Number: _____

Other Location Information: _____

Prior or Current Crime of Violence if Known: Possession of a Controlled Substance

Describe: _____
_____

Comments: _____
_____

This Completed Form Must be Emailed to:

Rhode Island Recovery Court Program
Attention: Kaitlin Swinson, Recovery Court Program Manager
recoverycourtprogram@courts.ri.gov

For use by the Office of the Attorney General or the Recovery Court Program Manager Only

Eligible ☐ Ineligible ☐