State of Rhode Island Judiciary

Superior Court
Adult Drug Court Program

Referral Form

*<u>*All Fields are Required - Form Will not be Processed if Incomplete*</u>*

Referral Date: _____

Name of the Defendant: _____ also known as _____

Date of Birth: _____

Referring Source/Attorney: _____

Source/Attorney: Telephone Number _____ Facsimile Number _____

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

Physical Location of the Defendant for Contact:

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

Street Address: _____

City/Town: _____ State: _____

Telephone Number: _____

Alternate Telephone Contact Number: _____

Other Location Information: _____

Prior or Current Crime of Violence if Known: _____

Describe: _____

_____

Comments: _____

_____

This Completed Form Must be Emailed to:

Rhode Island Adult Drug Court Program
Attention: Kaitlin Swinson, Adult Drug Court Program Manager
kswinson@courts.ri.gov

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

Eligible ☐ Ineligible ☐