



State of Rhode Island Judiciary

Superior Court Adult Drug Court Program

Referral

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

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: _____

Comments: _____

This Completed Form Must be Emailed to:

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

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

Eligible Ineligible