

R.I. Adult Drug Court Referral Form

ALL FIELDS ARE REQUIRED - FORM WILL NOT BE PROCESSED IF INCOMPLETE

Referral Date _____

Name of Defendant: _____ A/K/A _____

D.O B. _____

Social Security # _____

Referring Source/ Attorney: _____

Source/Attorney Phone Number _____

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

Physical Location of Defendant for Contact:

ACI: _____ Division: _____ Bail Status: _____ Other: _____

Street Address: _____

City/Town: _____ State: _____

Telephone Number: _____

Alternate Telephone Contact #: _____

Other Location Information: _____

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

Describe: _____

Comments: _____

This Completed Form Must be Faxed to:

RI Adult Drug Court
Attn: Matt Weldon, Adult Drug Court Manager
FAX#: 222-8831

FOR OFFICIAL USE BY THE DEPT. OF THE ATTORNEY GENERAL ONLY

Eligible _____ Ineligible _____