

Case #(s) _____

**McHENRY COUNTY
ADULT DRUG COURT
Phone 815/334-4502 Fax 815/334-4691
REFERRAL**

Referral must be made within 60 days of first appearance with counsel.

Name: _____ DOB: _____

Phone Number: _____

This individual is is not currently an inmate in the McHenry County Correctional Facility.

As a program requirement a participant needs to reside within the boundaries of McHenry County.

This individual is is not currently a resident of McHenry County.

Referral from: (Include Contact Information)

Public Defender _____

Private Attorney _____

Other _____

Date of First Court Appearance with Counsel (if known): _____

Additional Information: _____

Signed _____

Date _____

PLEASE FORWARD THIS REFERRAL TO THE SPECIALTY COURTS DIRECTOR
