Time to Evaluate

Referral Form

Healthcare Providers, Therapists, and Care Coordinators: Please complete this form to refer a child, adolescent, or adult for a comprehensive autism evaluation. Our team will contact them within one business day to schedule a consultation—no waitlist required. Thank you for partnering with Time to Evaluate to support timely access to autism evaluations in New Mexico.

Instructions:

1. Please complete all required sections and include any information that may help our team connect meaningfully with the individual or family being referred.
2. Send the completed referral and any supporting documentation through our secure e-fax to: (505) 212-4084

Referring Provider Information

Referring Individual's Full Name:

Practice / Organization Name:

Referring Email: Referring Phone:

Patient Information

Patient Full Name:

Patient Birth date: Gender:

Preferred Language: ☐ English ☐ Spanish ☐ Other:

Caregiver Information

Only provide contact information if the patient is also the caregiver.

Caregiver Full Name:

Caregiver relation to patient:

Caregiver Email: Caregiver Phone:

Referring Details

Reason for referral:

☐ Check if attachments are included. Number of attachments _____