Anxiety Disorders Treatment Center
Suite 110
5003 Southpark Drive
Durham, NC 27713
Phone: 919-942-0700
Fax: 866-774-9511
www.anxieties.com
e-mail: drwilson@anxieties.com

2-Day Treatment Group
HEALTH PROFESSIONAL REFERRAL

The person sending you this form is registering for a two-day treatment group and must be referred by a health professional who has conducted at least a diagnostic evaluation. They request that you complete this form and send it to our office, either electronically or through the mail. ~ Reid Wilson, Ph.D.

You may e-mail this form to me at drwilson@anxieties.com or mail it to me at the above address.

Patient name:

Date of most recent diagnosis:

Diagnosis:

- ☐ panic disorder
- ☐ social anxiety disorder
- ☐ obsessive-compulsive disorder
- ☐ co-morbid disorders

list

other information:

Your name, degree:

Address:

Address:

State/Province:

Zip/Postal Code:

Country:

Email:

Phone:

Your signature (type name)

today's date