WellFlorida Council
Working Together for Healthy Communities

1785 NW 80th Blvd., Gainesville, FL 32606
Ph: (352) 313-6500 x8043
Fax: (352) 313-6515
www.wellflorida.org

I. Provider Information (Required)

Clinic: _____ Provider Name: _____

Date of Most Recent Office Visit: _____ Fax Number: _____

Client Concerns: _____
_____
_____

Main Contact Person: Valeria Crawford Email: vcrawford@wellflorida.org
Phone: 352-313-6500 x8043 Fax: 352-313-6515
Address: 1785 NW 80th Blvd City: Gainesville State: FL Zip Code: 32606

II. Patient Information (Required)

Patient First Name: _____ Patient Last Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email: _____ Phone Number: _____

The best time to call you: (check one)

☐ Morning: 8am-Noon ☐ Afternoon: Noon-5pm ☐ Anytime

Can we leave a voicemail? (check one) ☐ Yes ☐ No

Can we text the provided number? (check one) ☐ Yes ☐ No

My signature gives permission for my provider to send this form to WellFlorida Council for the linkage and adherence program. I understand that I will be contacted within the next week.

Patient Signature: _____ Date: _____