STARNet
South Texas Ambulatory Research Network

Member Enrollment Form

PLEASE PRINT

PART 1 - PHYSICIAN'S CONTACT INFORMATION

Lead Physician Name: _____ Practice Name: _____

Practice Address: _____
Street Address City State Zip Code

Phone: _____ Fax: _____ E-mail: _____

Preferred way to communicate: ☐ Phone ☐ Fax ☐ E-mail ☐ Mail

PART 2 – PREFERRED PRACTICE CONTACT

(Please identify a preferred contact at your practice willing to contribute/participate in a study.)

Contact Name: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

Contact's Address *(if different from above)*: _____
Street Address City State Zip Code

PART 3 - INSTITUTIONAL REVIEW BOARD INFORMATION

(Please indicate if your practice is required to report to a local institutional Review Board for approval of research projects)

☐ Required to report to a local IRB ☐ Not required to report to a local IRB ☐ Don't Know

PART 4 – PRACTICE DESCRIPTIVE INFORMATION

1. How many patients are in your practice? _____

2. What are your office hours?
   Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____

3. What is the average number of daily and monthly patient visits? _____ *visits/**day*** _____ *visits/**month***

4. Is the practice taking new patients? ☐ Yes ☐ No
   a. If no, how many months has the practice been closed to new patients? _____

5. Practice Specialty *(Check all that apply):*
   ☐ Family Medicine ☐ Internal Medicine ☐ Pediatrics ☐ Obstetrics/Gynecology
   ☐ Other (specify): _____

6. How many clinicians and nursing staff are in the practice?

# of Clinicians	# of half-days/week (FTE)	# of Nursing Staff	# of half-days/week (FTE)
_____ MD	_____	_____ RN	_____
_____ FNP	_____	_____ LVN	_____
_____ PA	_____	_____ MA	_____

7. How many people in the practice are bilingual? _____# of Clinicians _____# of Staff

8. Please describe the age breakdown of the practice's patient panel *(must total 100%)*:
   _____% Birth – 18 years _____% 19 – 65 year _____% Over 65 years

9. Please describe the payment breakdown of the practice's patient panel *(must total 100%)*:
   _____% Medicare _____% Medicaid _____% Tricare
   _____% Other Insurance _____% No Insurance _____% Other
   If other, please list types: _____

PART 5 – PRACTICE PATIENT INFORMATION

1. Please describe the approximate racial breakdown of your patient population *(must equal 100%)*:
   _____% White _____% Asian or other Pacific Islander
   _____% Black _____% Other
   _____% American Indian or Alaska Native

2. Please describe the approximate ethnic background of your patient population *(must equal 100%)*:
   _____% Hispanic _____% Non-Hispanic

3. Please give the approximate percentages of patients for whom Spanish is the first language:
   _____% Spanish _____% Other *(Specify)* _____ _____% Other *(Specify)* _____

4. How many different insurance plans do you have a contract or agreement with? _____

5. On average, what is the number of follow-up calls or faxes your practice receives each week for RX issues? _____

6. Please list the hospitals where you have active privileges: _____
   _____

7. Are you still admitting your own patients to the hospital or are you using a hospitalist?
   ☐ Yes, I admit ☐ No, I use a hospitalist ☐ Both

PART 6 – DATA SYSTEM AND TECHNOLOGY CHARACTERISTICS

1. Does your office have an Electronic Health Record (EMR)? ☐ Yes ☐ No
   a. <u>If yes:</u>
      Please indicate the name of the system: _____, how long it has been in use? _____
      What do you use your EMR for (check all that apply):
      ☐ E-prescribing ☐ Import lab data ☐ Import x-ray reports
      ☐ Create reports on groups of patients (like those with diabetes)
      ☐ Other _____
   b. <u>If no:</u>
      Are you planning to install an EMR? ☐ Yes, within ___months or ___years ☐ No

Please print the name of the person who completed this form: _____

RETURN THIS FORM TO: Marisa F. Rodriguez, STARNet Coordinator
Rodriguezm21@uthscsa,edu, Fax: 210-567-7868

Information provided will remain confidential and viewed only by authorized STARNet personnel