Australasian Rehabilitation Outcomes Centre (AROC) Membership Form
– Inpatient / Ambulatory Rehabilitation Service Submitting Data –

Section A — REHABILITATION SERVICE DETAILS **COMMONWEALTH PROVIDER UNIT NUMBER**_____

Official name of rehabilitation service _____

Name of rehabilitation service to appear on benchmark report _____

Mailing address _____

Street address _____

Rehab ward phone (____)_____ Rehab ward email _____

Please indicate which sector your service belongs to:

❍ Public: Area Health Service/District _____

❍ Private: Parent company (if applicable) _____

Please indicate which best describes your service: ❍ Stand-alone rehabilitation service ❍ Co-located rehabilitation service

Total number of designated rehabilitation beds: _____ Delineated level of rehabilitation service: Level _____

Section B — DATA COLLECTION

AROC members submit data using the AROC Online Services (AOS) Data Entry System and / or the AOS Data Upload System.

What AROC data will your service be collecting? ❍ Inpatient only ❍ Ambulatory only ❍ Both inpatient & ambulatory

INPATIENT (if applicable):

Mode of data submission: ❍ AOS Data Entry System ❍ AOS Data Upload System
Please specify data capture software used: _____

AMBULATORY (if applicable):

Mode of data submission: ❍ AOS Data Entry System ❍ AOS Data Upload System
Please specify data capture software used: _____

Section C — DATA ENTRY STAFF (APPLICATION FOR AOS ACCOUNT)

Please enter details of staff who will be entering data into the AOS Data Entry System (if applicable). An AOS account will be set up and emailed to each individual.

Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		
Data entry for:	❍ Inpatient only ❍ Ambulatory only ❍ Both	❍ Inpatient only ❍ Ambulatory only ❍ Both

Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		
Data entry for:	❍ Inpatient only ❍ Ambulatory only ❍ Both	❍ Inpatient only ❍ Ambulatory only ❍ Both

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Section D — REHABILITATION SPECIALTY DETAILS

INPATIENT SERVICES ONLY

Number of **general** rehabilitation beds: _____

Number of dedicated **brain injury** unit beds: _____

Number of dedicated **spinal** unit beds: _____

Number of dedicated **stroke** unit beds:

Other dedicated beds:

Type of bed: _____ Number of dedicated beds: _____

Type of bed: _____ Number of dedicated beds: _____

INPATIENT & AMBULATORY SERVICES

Specialty areas or programs (tick all that apply)

	Inpatient	Outpatient	Community	Same day
Orthopaedic	❍	❍	❍	❍
Amputee	❍	❍	❍	❍
Neurological	❍	❍	❍	❍
Spine	❍	❍	❍	❍
Brain injury	❍	❍	❍	❍
Pain management	❍	❍	❍	❍
Reconditioning	❍	❍	❍	❍
Cardiac	❍	❍	❍	❍
Pulmonary	❍	❍	❍	❍

Other (please specify): _____

_____

_____

_____

_____

_____

_____

_____

_____

Specialists' position in organisation	Specialists' name	Inpatient	Ambulatory	Rehabilitation physician	Geriatrician	General physician	Other (please specify)
		❍	❍	❍	❍	❍	
		❍	❍	❍	❍	❍	
		❍	❍	❍	❍	❍	
		❍	❍	❍	❍	❍	
		❍	❍	❍	❍	❍	
		❍	❍	❍	❍	❍	

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Section E — REHABILITATION STAFF DETAILS

AROC contact role:	**Director of Inpatient Rehabilitation**	**Director of Ambulatory Rehabilitation**
Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		

AROC contact role:	**Inpatient Rehabilitation Unit Manager**	**Ambulatory Rehabilitation Program Manager**
Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		

AROC contact role:	**Inpatient Data Contact Person**	**Ambulatory Data Contact Person**
Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		

AROC contact role:	**Nurse Unit Manager**	**FIM Facility Coordinator**
Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		

Section F — FIM CREDENTIALING DETAILS

Number of staff currently undertaking FIM assessments: _____

Number of staff currently credentialed in the FIM: _____

Number of staff currently trained but not credentialed in the FIM: _____

Estimated number of staff to be credentialed in the FIM this calendar year: _____

Estimated number of staff to be credentialed in the FIM next calendar year: _____

Name of current FIM Facility Trainer(s): _____

_____

Name of prospective FIM Facility Trainer(s): _____

_____

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Section G — USE OF AROC DATA

AROC reserves the right to use non-identifiable data for reporting, benchmarking and research purposes.

Rehabilitation services will receive reports with their data benchmarked against the national and other benchmark data sets. However, individual rehabilitation services will not be identified in reports sent to any third party.

AROC will only release information that identifies a rehabilitation service with the consent of that service. Participating rehabilitation services will be given the opportunity to give consent to AROC to release data that identifies a service under one of the following circumstances:

- Under an industry regulation, a copy of which is held by AROC
- As a condition of funding, a copy of which is held by AROC
- In accordance with an existing contract between the submitting organisation and an insurer or other third party payer
- To any other AROC member nominated by the submitting organisation

Please enter details of staff within your service with the authority to consent to the release of data in the above circumstances.

Name:		
Position in organisation:		
Telephone / Mobile:		
E-mail address (work):		
Authority for data:	❍ Inpatient only ❍ Ambulatory only ❍ Both	❍ Inpatient only ❍ Ambulatory only ❍ Both

Section H — CONFORMITY WITH PRIVACY LEGISLATION AND OTHER MEASURES DESIGNED TO PROTECT THE CONFIDENTIALITY OF CONSUMERS

We_____ (NAME OF SERVICE) accept responsibility for ensuring that the data we submit to AROC will be collected in accordance with relevant Commonwealth, State or Territory legislation designed to protect the privacy of individual patients and absolve AROC of any responsibility in relation to the way that data is collected or stored by the service or transmitted to AROC.

Yes / No (please circle)

Section I — DATE OF COMMENCEMENT

Date from which data will be / has been submitted to AROC: _____/_____/_____

Comment: _____

Section J — NAME OF INDIVIDUAL MAKING THE APPLICATION ON BEHALF OF THE ORGANISATION

The person completing this membership form has the authority within the organisation to provide the above information.

Name: _____

Position in organisation: _____

Signature: _____ Date: _____/_____/_____

COMPLETED FORMS SHOULD BE SCANNED AND EMAILED TO aroc@uow.edu.au