

## FESC Outcome Log

1. Patient Number:

2. Date/Time **In:** \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_:\_\_\_\_ am pm

3. Chief complaint:

4. Date/Time **Out:** \_\_\_\_/\_\_\_\_/\_\_\_\_ \_\_\_\_:\_\_\_\_ am pm

5. Diagnosis at discharge:

6. Select FESC type:

\_\_\_\_ A. Transfer to hospital:

- commercial air
- medevac
- ferry or boat
- vehicle (i.e., ambulance, private vehicle)
- Coast Guard helicopter
- other (specify) \_\_\_\_\_

Did any of the following factors influence encounter length?

\_\_\_ weather, \_\_\_ darkness, or \_\_\_ unavailability of preferred method of transportation  
\_\_\_ other \_\_\_\_\_

Destination: (site specific)

Transfer company: (site specific)

Did your organization provide a paid escort for the transfer? \_\_\_yes \_\_\_no

\_\_\_\_ B. Monitoring/Observation

Disposition:

- \_\_\_ Discharged Home
- \_\_\_ Referred for Non-Emergent Follow-up
- \_\_\_ Transferred; if yes, why:
  - Patient deteriorated
  - Patient failed to improve as expected
  - Patient was safely monitored and observed until non-emergency transport was available
- \_\_\_ Other \_\_\_\_\_

\_\_\_ C. Other

- \_\_\_ Patient recovered while waiting for transport
- \_\_\_ Patient refused transport
- \_\_\_ Receiving hospital refused patient
- \_\_\_ Patient died
- \_\_\_ Other

7. **For monitoring/observation encounters:** How did the availability of a FESC option affect the care given?

- \_\_\_ avoided emergency transfer and subsequent hospitalization
- \_\_\_ delayed emergency transfer and subsequent hospitalization
- \_\_\_ avoided risk of sending patient home
- \_\_\_ allowed patient to seek non-emergent transport instead of emergency transport

8. Describe the clinical outcome of the FESC encounter. Include the referral facility diagnosis and any unanticipated results.

**Financial/Coding Information**

9. ICD-9 Codes:

10. CPT Codes:

11. Total billed:

12. Primary Payor: \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Private Ins.  
\_\_\_ Self Pay \_\_\_ IHS/Tribal \_\_\_ Other

13. Secondary Payor: \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Private Ins. \_\_\_ HRSA Sliding Fee  
\_\_\_ Self Pay \_\_\_ IHS/Tribal \_\_\_ Other

14. Additional Payor(s) (select all that apply): \_\_\_ Medicare \_\_\_ Medicaid \_\_\_ Private Ins.  
\_\_\_ HRSA Sliding Fee \_\_\_ Self Pay \_\_\_ IHS/Tribal \_\_\_ Other