### **Medication Monitoring Feedback Loop Form**

#### Q.I. Confidential

***Information***

(McFloop)

**TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## **Treating Physician**

**FROM: Medication Monitoring Committee**

**RE: Program Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Case #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Summary of Recommendations/Requests for Action:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewer Signature & Discipline Date**

**Response/ Action taken by Treating Physician to Committee**

(Written documentation/proof must be provided within 2 weeks)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature & Discipline Date**

**Verification of Physician Response**

**( ) Approved**

**( ) Disapproved** (Forwarded to Medical Director)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reviewer Signature & Discipline Date**

**Please complete a McFloop Form if there are any variances and submit to County QM along with this tool and**

**Submission Form. Forms can be sent via confidential fax to 619-236-1953 or encrypted email to: Qimatters.hhsa@sdcounty.ca.gov.**