QA Confidential Information

County of San Diego DMC-ODS
Medication Monitoring Feedback Loop Form (McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____

Patient Name _____

Client ID# _____

Summary of Recommendations/Requests for Action by Reviewing Physician:

_____

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 Reviewing Physician Response

◯ **Approved**

◯ **Disapproved** (Forward to QA Unit)

_____

Reviewer Signature & Discipline **Date**