County of San Diego DMC-ODS
QA Medication Monitoring Submission Form

PROGRAM NAME:		
DATE:	**CONTRACT #:**	**DMC PROVIDER #:**
REPORT SUBMITTED BY:		**PHONE:**

QUARTER 1	QUARTER 2	QUARTER 3	QUARTER 4
Jul 1 – Sep 30	Oct 1 – Dec 31	Jan 1 – Mar 31	Apr 1 – Jun 30
Due Oct 15	*Due Jan 15*	*Due Apr 15*	*Due Jul 15*

Committee Member: Discipline: Committee Member: Discipline:

Description of Activities:

	Total number of records screened this quarter		# McFloops Approved/Completed
	Total number of variances identified		# McFloops Outstanding
	Total # of open charts receiving medication at clinic		Total number of McFloops required
	# McFloops Disapproved *Disapproved McFloop forms must be* ***faxed*** *in to 619-236-1953*		

Total number of variances for all records screened this quarter, listed by item:

1	2	3	4	5	6	7	8	9	10	11
12	**13**	**14**	**15**							

Program Attestation: All prescribers are included in the quarterly sample? ■ Yes ☐ No

If no, please explain:

Email this form to: QIMatters.hhsa@sdcounty.ca.gov

Do not email Medication Monitoring Tools

Do not email McFloop Forms unless a McFloop has been disapproved.

This form may also be faxed to the QI Unit at 619-236-1953