County of San Diego DMC-ODS
Medication Monitoring Tool

Confidential Information – Quality Improvement material for risk management purpose only

IDENTIFYING INFORMATION

Patient Name: UCN#:

Review Date: Period of Review From: To:

Type of Chart: ☐ OTP ☐ MAT

Name of Patient's Physician:

REVIEW QUESTIONS

As indicated by this documentation:	Yes	No	N/A
1. Has the physician made substance use a diagnosis on the treatment plan/problem list? Comments:	☐	☐	☐
2. Has the physician documented symptoms that support the included SUD diagnosis on all intake/follow-up? Comments:	☐	☐	☐
3. Is the treatment provided by the SUD certified physician within the clinical guidelines for MAT services? Comments:	☐	☐	☐
4. Are the dosage levels within the general standards of practice? Comments:	☐	☐	☐
5. Does documentation indicate compliance (or lack of) with medication regimen? Comments:	☐	☐	☐
6. Is the presence or absence of medication side-effects documented? Comments:	☐	☐	☐
7. Did the physician document safety and effectiveness of medications? Comments:	☐	☐	☐
8. Did the physician identify clinical issues affecting client? Comments:	☐	☐	☐
9. Are reasons for changes in medication or dosages documented? Comments:	☐	☐	☐
10. Were Laboratory panels ordered and reviewed? Comments:	☐	☐	☐
11. Does documentation indicate response to medications? Comments:	☐	☐	☐
12. Are medication consent forms complete, appropriate, and up to date? (i.e. for clients under 18: Parental consent completed) Comments:	☐	☐	☐
13. Did the physician document physical health issues? Comments:	☐	☐	☐
14. Was test performed for Oxycodone and Fentanyl? Comments:	☐	☐	☐
15. For clients prescribed controlled substances, there is documentation that the CURES database is reviewed upon initial prescription and at least once every 6 months thereafter if the substance remains part of their treatment. Comments:	☐	☐	☐

ADDITIONAL COMMENTS:

Reviewing Physician
printed name and credential: ______________________ Date: ____________

Reviewing Physician
signature and credential: ______________________ Date: ____________