QA Confidential Information

DMC-ODS Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name:**

Client Name: _____ **MRN #**_____

Summary of Recommendations/Requests for Action:

Reviewer Signature & Credentials **Date**

Response/ Action taken by Treating Physician to Committee
(Written documentation/proof must be provided within 2 weeks)

Physician Signature & Credentials

Date

Verification of Physician Response

☐ **Approved**

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

Reviewer Signature & Credentials **Date**

Please complete a McFloop Form if there are any variances and submit to County QA 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.