### **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.**