Q.I. Confidential Information

SUD Medication Monitoring Feedback Loop Form

(McFloop)

TO: _____
Treating Physician

FROM: **Medication Monitoring Committee**

RE: **Program Name** _____

Patient Name _____

UCN# _____

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 QM Unit)

_____

Reviewer Signature & Discipline **Date**