

**County of San Diego DMC-ODS
QA Medication Monitoring Tool**

Confidential Information – Quality Improvement material for risk management purpose only

IDENTIFYING INFORMATION

Patient Name: _____ Client ID#: _____
 Review Date: _____ Period of Review From: _____ To: _____
 Type of Chart: NTP MAT AWM
 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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the physician documented symptoms that support the included SUD diagnosis on all intake/follow-up? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the treatment provided by the SUD certified physician within the clinical guidelines for MAT services? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Are the dosage levels within the general standards of practice? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Does documentation indicate compliance (or lack of) with medication regimen? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Is the presence or absence of medication side-effects documented? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Did the physician document safety and effectiveness of medications? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Did the physician identify clinical issues affecting client? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are reasons for changes in medication or dosages documented? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Were Laboratory panels ordered and reviewed? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does documentation indicate response to medications? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Are medication consent forms complete, appropriate, and up to date? (i.e. for clients under 18: Parental consent completed) Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Did the physician document physical health issues? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Was test performed for Oxycodone and Fentanyl? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADDITIONAL COMMENTS:

Reviewing Physician
printed name and credential: _____ Date: _____

Reviewing Physician
signature and credential: _____ Date: _____