

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.