Medication Monitoring Submission Form - Adult/Older Adult Outpatient

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| --- | --- | --- | --- | --- |
| Program Name: Click or tap here to enter text. | | | | |
| Report Submitted By: Click or tap here to enter text. | | | Date: Click or tap here to enter text. | |
| Q1. | Q2. | Q3. | | Q4. |
| July 1-September 30  Due: October 15th | October 1- December 31st  Due: January 15th | January 1st- March 31st  Due: April 15th | | April 1st- June 30th  Due: July 15th |
| No medications distributed this quarter | | | | |

|  |  |
| --- | --- |
| **Medication Monitoring Committee** | |
| Committee Member | Committee Member Credentials |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |

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| **Program Attestation** | | |
| All prescribers are included in the quarterly sample: | Yes | No |
| If “*No*”, please explain: Click or tap here to enter text. | | |

|  |  |
| --- | --- |
| Description of Activities | Total Number |
| Total number of records screened this quarter | Click or tap here to enter text. |
| Total number of variances identified | Click or tap here to enter text. |
| Total number of McFloops required | Click or tap here to enter text. |
| Total number of McFloops disapproved  *(Disapproved McFloop forms must be faxed in)* | Click or tap here to enter text. |
| Total number of Mcfloops approved/completed | Click or tap here to enter text. |
| Total number of McFloops outstanding | Click or tap here to enter text. |
| Total number of open charts receiving medication | Click or tap here to enter text. |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Total Variances** | | | | | | | | | | | |
| 1 | 2a | 2b | 2c | 2d | 2e | 2f | 3 | 4 | 5 | 6 | 7 |
| # | # | # | # | # | # | # | # | # | # | # | # |
| 8a | 8b | 8c | 8d | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| # | # | # | # | # | # | # | # | # | # | # |

Please complete and submit to County QA along with the *Medication Monitoring Tool* and *McFloop* (if applicable). Forms can be sent via confidential fax to 619-236-1953 or through encrypted email at: QIMatters.hhsa@sdcounty.ca.gov