County of San Diego DMC-ODS
Medication Monitoring Tool

Confidential Information – Quality Improvement material for risk management purpose only

IDENTIFYING INFORMATION

Patient Name: UCN#:

Review Date: Period of Review: To:

Type of Chart: ☐ OTP ☐ MAT

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? Comments:	☐	☐	☐
2. Has the physician documented symptoms that support the included SUD diagnosis on all intake/follow-up? Comments:	☐	☐	☐
3. Is the treatment provided by the SUD certified physician within the clinical guidelines for MAT services? Comments:	☐	☐	☐
4. Are the dosage levels within the general standards of practice? Comments:	☐	☐	☐
5. Does documentation indicate compliance (or lack of) with medication regimen? Comments:	☐	☐	☐
6. Is the presence or absence of medication side-effects documented? Comments:	☐	☐	☐
7. Did the physician document safety and effectiveness of medications? Comments:	☐	☐	☐
8. Did the physician identify clinical issues affecting client? Comments:	☐	☐	☐
9. Are reasons for changes in medication or dosages documented? Comments:	☐	☐	☐
10. Were Laboratory panels ordered and reviewed? Comments:	☐	☐	☐
11. Does documentation indicate response to medications? Comments:	☐	☐	☐
12. Are medication consent forms complete, appropriate, and up to date? Comments:	☐	☐	☐
13. Did the physician document physical health issues? Comments:	☐	☐	☐
14. Was test performed for Oxycodone and Fentanyl?	☐	☐	☐

ADDITIONAL COMMENTS:

Reviewing Physician printed name and credential: ______________________________ Date: ____________________

Reviewing Physician signature and credential: ______________________________ Date: ____________________