Department of Veterans Affairs
VACT Office of Community Care
HIMS / OCC MSA Cover Sheet

LAST, FIRST NAME:

LAST 4 OF SSN:

D.O.B.:

STATUS:

- **NO CONSULT** ☐
- SCHEDULED ☐
- COMPLETED ☐

CONSULT #:

DATE OF CONSULT:

HIMS CPRS IDENTIFIER

NO CONSULT

D.O.S.:

ADMISSION OR MULTIPLE VISITS

- -

PATIENT IS STILL ADMITTED ☐

COMMUNITY PROVIDER:

DATE:

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