

**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**

D.O.S.:

**ADMISSION OR
MULTIPLE VISITS**

-

PATIENT IS STILL ADMITTED

**COMMUNITY
PROVIDER:**

DATE:

**REVIEWER
INITIALS**

**TOTAL #
PAGES**