

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