# Ophthalmology
# Refractive Surgery

Name: ______________________________________________________________

SSN: _______________________________________________________________

Phone #: ____________________________________________________________

Unit: _______________________________________________________________

Email (AKO): _______________________________________________________

# SOUTHERN REGIONAL MEDICAL COMMAND
## Warfighter Refractive Eye Surgery Program

## Instructions for Completing the Enclosed Forms
*(You must be 21 years old and meet the eligibility requirements to be considered for refractive surgery)*

1. Please complete all the information in the forms and ensure that it is LEGIBLE, so please print.

2. Since we will use email as the first line of communication please make sure that the email address you provide is one that you regularly use. Please email (address below) to make sure all information is received at the time you sent it.

3. If at any time you change your contact information, please be sure to let us know the new information.

4. YOU MUST INCLUDE A COPY OF YOUR EYE PRESCRIPTION THAT IS *OLDER* THAN ONE YEAR to have a completed packet to be reviewed and approved.

5. Instructions for each form enclosed below are as follows:

   - ***PRK Application Form:*** be completely filled out and signed by you.
   - ***Commander's Authorization Letter:*** Turn in to be signed by your commander. If your commander is not available and someone signs in their place, assumption of command orders must accompany your authorization.
   - ***Patient History Questionnaire:*** To be completely filled out and signed by you down to the technician comments. Do not leave any questions or box blank, use “n/a” or “never” as an the answer.
   - ***Managed Care Agreement:*** Needs to be filled out and signed by you. Take this with you to your pre-operative evaluation to be signed by the doctor who will be responsible for your surgery follow-up care.

6. A complete packet includes the following (please do not include a copy of these instructions):
   1. Completed *PRK/LASIK Application* Form
   2. Signed *Commander’s Authorization* Letter
   3. Completed *Patient History Questionnaire* Form
   4. Signed *Managed Care Agreement* by you, the patient, and your local eye doctor

# Commander's Authorization
# Warfighter Refractive Eye Surgery Program (WRESP)

1. I hereby give my endorsement/permission for the following Soldier to be evaluated and considered for enrollment in the WRESP and for their PRK/LASIK eye surgery if eligible.

**Name:** ______________________________ **Rank:** __________
Last, First, MI

**SSN:** __________ **ETS Date:** __________ **MOS:** _____ **Duty Title:** __________

**Assigned Unit:** ______________________________

**Contact Address:** ______________________________

**Contact Phone: (day)** __________________ **(evening)** __________________

**E-mail address:** ______________________________

**Likely to do travel for the following reasons in the next 4 months? (please circle)** PCS TDY Deploy School **Projected date (if known):** __________

2. I certify that the following are true and will inform local MTF eye clinic if Soldiers circumstances change:
   a. Soldier has 18 months remaining on Active Duty
   b. Soldier has no adverse personnel actions pending
   c. Soldier will remain CONUS for at least 60-90 days

3. I realize that after surgery, the Soldier will have at least 4 days up to 7 days of convalescent leave. In addition, I understand that the SM will have the following profile for a minimum of 30 days:
   a. No field duty or driving military vehicles
   b. No organized PT – may do modified individual PT
   c. No swimming, protective mask use, or use of camouflage face paint
   d. Needs to wear sunglasses at all times
   e. Non-deployable

4. I further realize that participation in this program requires a considerable investment of time resulting in absences from duty and will ensure that the Soldier will keep all appointments. Minimum requirements are as follows:
   a. Initial evaluation (local medical treatment facility (MTF)) – up to half a day
   b. Surgery – one week off work, up to two weeks, especially if Soldier has to travel for surgery
   c. Postoperative evaluations (local MTF) – normally scheduled at a minimum of 1, 5, 30, and 90 days after surgery. Appointments can follow until 1 year post op.

**5. Please circle one of the following** according to which category applies to this individual:
   a. Priority 1 – Deploying/ Combat Arms MOS
   b. Priority 2 – Attached to Combat Arms unit
   c. Priority 3 – Space Available

6. I understand that if Soldier needs to travel to another facility to receive refractive surgery, all TDY costs will be incurred by the Unit or the Soldier receiving the elective refractive eye surgery.

7. This authorization is good for 90 days from the date it is signed by the Battalion Commander. If surgery is scheduled more than 90 days from the date it is signed, re-authorization will need to be accomplished.

*By endorsing the Soldier I certify that they are available for surgery at any time during the next 90 days.*

| | |
|---|---|
| Company Commander's Signature | Battalion Commander's Signature |
| Company Commander's Name and Rank | Battalion Commander's Name and Rank |
| Date    Phone | Date    Phone |
| Company Commander's Email Address | Battalion Commander's Email Address |

## MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE **PATIENT HISTORY QUESTIONNAIRE** | **DATE** *(DD/Mon/YYYY)*

| Last Name, First Name, MI | | | | Rank/Grade | MOS | Occupation/Duty Title |
|---|---|---|---|---|---|---|
| SSN | Date of Birth | Age | Home Phone | Work Phone | Address | |
| Emergency Contact: *(not the person you bring with you)* | | | Phone | Relationship | Your Primary E-mail | |

List some of your hobbies or activities that require visual needs:
(example: biking, crafts, computers, sports, etc.)

1. ______
2. ______
3. ______
4.

What do you hope to achieve from having laser eye surgery?
(example "to be able to wake up in the morning and see the clock")

1. ______
2. ______
3. ______
4.

**REFRACTIVE HISTORY**

How many years have you worn glasses?

Ever worn bifocals? ☐Yes ☐No

How old is your current glasses prescription?

How long have you worn contact lenses?

Last worn? *(DD MON YYYY)*

Contact lens type: ☐ Soft ☐Rigid

Brand worn:

Have you ever had difficulty with glasses or contact lens wear?
(If YES, please explain further)

**OCULAR HISTORY**

Do you or have you ever had the following eye problems?

| | | |
|---|---|---|
| Amblyopia / lazy eye | ☐Yes | ☐No |
| Cataracts | ☐Yes | ☐No |
| Conjuctivitis, recurrent | ☐Yes | ☐No |
| Corneal ulcer | ☐Yes | ☐No |
| Double Vision | ☐Yes | ☐No |
| Dry eyes | ☐Yes | ☐No |
| Glaucoma | ☐Yes | ☐No |
| High eye pressure | ☐Yes | ☐No |
| Herpes simplex / Zoster | ☐Yes | ☐No |
| Keratoconus | ☐Yes | ☐No |
| Retinal problems | ☐Yes | ☐No |
| Trauma | ☐Yes | ☐No |
| Other (specify) | | |

**ALLERGIES**

Do you have any allergies to medications? ☐Yes ☐No
*(Please list medication and reaction)*

**MEDICATIONS**

Are you taking or have you taken any of the following?

| | | | Date last taken: |
|---|---|---|---|
| Accutane (isotretinoin) | ☐Yes | ☐No | ______ |
| Birth control pill | ☐Yes | ☐No | ______ |
| Cordarone (amiodarone) | ☐Yes | ☐No | ______ |
| Immunosuppressants | ☐Yes | ☐No | ______ |
| Imitrex (sumatriptan) | ☐Yes | ☐No | ______ |
| Steroid medication | ☐Yes | ☐No | ______ |

List other medications that you are currently taking: (or say "none")

**MEDICAL HISTORY**

Do you or have you ever had the following?

| | | |
|---|---|---|
| Arthritis | ☐Yes | ☐No |
| Breathing Problems | ☐Yes | ☐No |
| Diabetes | ☐Yes | ☐No |
| Heart Problems | ☐Yes | ☐No |
| High Blood Pressure | ☐Yes | ☐No |
| Migraine Headaches | ☐Yes | ☐No |
| Pacemaker | ☐Yes | ☐No |
| Immunosuppression/HIV | ☐Yes | ☐No |
| Other Medical Problems (specify) | | |

**OCULAR SURGERY**

Have you ever had surgery or laser treatments on your eyes?
☐No ☐Yes (specify)

**Name of Eye Care Provider** | **Phone**

**PATIENT SIGNATURE:**______

**TO BE COMPLETED BY THE WARFIGHTER LASER CENTER STAFF:**

**SURGERY TECHNICIAN COMMENTS**

Technician Signature:______

**SURGERY PHYSICIAN COMMENTS**

| PREPARED BY *(Signature & Title)* | DEPARTMENT/SERVICE/CLINIC | *DATE (YYYYMMDD)* |
|---|---|---|

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL

☐ OTHER EXAMINATION OR EVALUATION

☐ DIAGNOSTIC STUDIES

☐TREATMENT

☐FLOW CHART

☐ OTHER *(Specify)*

## SRMC PRK/ LASIK Application Form
## Warfighter Refractive Eye Surgery Program (WRESP)

(Read Instructions completely before filling out application)

***INSTRUCTIONS:***

1. *Type or print legibly all information on this form.*
2. ***Enter all dates in the format dd-mon-yyyy (example: 05-Aug-2006).***
3. ***Applicant must* DISCONTINUE CONTACT LENS WEAR IMMEDIATELY *after submitting application. Patients must be out of soft contacts a* minimum 30 days *prior to initial screening and be at least 21 years old. Patient's will not be referred to a laser center until corneal stability is demonstrated.***
4. ***FIRST Contact your Unit Surgeon to determine if you need to complete any additional waiver's or authorizations before receiving surgery especially if you are in aviation, or special duty status.***
5. *Submit this completed form and your signed Commander's Authorization to your local Medical Treatment Facility eye clinic to be scheduled for a screening appointment.*
6. *Incomplete forms will not be accepted and will be returned. Please allow three weeks for processing.*
7. *You will be notified of your status by email so please make sure that the email address you provide is one that you regularly use.*

| ***SRMC Warfighter Laser Centers*** | ***Location*** |
|---|---|
| Wilford Hall Medical Center | Lackland AFB, San Antonio, TX |
| Carl R. Darnall Army Medical Center | Fort Hood, Killeen, TX |
| US Air Force Academy | Colorado Springs, CO |

| Last Name: | First Name: | MI: | Rank/Grade: | Date of Application: |
|---|---|---|---|---|
| | | | | |

| SSN: no dashes | Date of Birth: dd/mon/yyyy | Age: | Sex: ☐Male ☐Female | MOS: | ETS Date: dd/mon/yyyy | Likely to Deploy, PCS or attend School in the next 12 months? Approximate Date: (if known) | ☐Deploy ☐PCS ☐School |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Unit:

AKO/Primary email address: (must be one you check regularly)

Duty Address:

Street: ______________________

______________________

City: ______________________

State, Zip: ______________________

Duty Phones:

Commercial: ______________________

DSN: ______________________

Fax:

Duty Status: ☐Active ☐Active Guard Reserves ☐National Guard ☐Reserves ☐Other______________________

Special Duty Status: (Check with your Unit Surgeon before submitting)

☐Airborne ☐Ranger ☐HALO ☐Aviation (please confer with you flight surgeon about additional paperwork)

☐Special Operations ☐SCUBA ☐Air Assault ☐Other:______________________

**MANDATORY QUESTIONS:**

*Your initials indicate you completely understand the statement or question. If you don't understand, ask your local eye care clinic for help.*

1. I understand that PRK/LASIK may not correct all my myopia, hyperopia, or astigmatism and that I may still need to wear glasses or contact lenses after PRK/LASIK for best correction of my vision. Initials:
2. I understand there is a chance I cannot be fitted with contact lenses after PRK/LASIK. Initials:
3. I understand that if PRK/ LASIK is not successful there is a possibility that I may lose my special duty status and/or may never meet vision standards for application into special duty programs. Initials:
4. I understand there is a small risk of not meeting relevant vision standards after PRK/LASIK. As a result, I may be disqualified permanently from certain career fields or even continued military service. Initials:
5. I understand that not everything can be assessed prior to my arrival at a GPRMC laser center, and upon further evaluation at the center I may be disqualified as a PRK/LASIK candidate and will NOT be treated. The final decision will be made by my surgeon. Initials:
6. I understand that if I am disqualified as a PRK/LASIK candidate after arriving at a GPRMC laser center, I will not be eligible for reimbursement of expenses incurred for travel to/from the DoD laser center, including, but not limited to, travel, meals, and lodging. (This does NOT apply if I am unit-funded.) Initials:
7. Any history of eye injury or other eye history that might impact PRK/LASIK (including previous refractive surgery)?
☐Yes ☐No
Explain if answered "yes":______________________ Initials:

| Signature of Applicant: | Print Clearly: (last name, first name, mi) | Date Signed: |
|---|---|---|
| | | |

## WHMC RERACTIVE SURGERY PATIENT INFORMATION FORM

*(This form is subject to the privacy act of 1974. Use blanket PAS, DD Form 2005)*

DATE

| | | | | |
|---|---|---|---|---|
| Last Name | | | Occupation | AFSC |
| First Name | MI | | Duty Address | |
| Social Security Number | | | | |
| Grade | Sex | Marital Status | City | State |
| Status<br>☐ Active Duty<br>☐ Reserve<br>☐ Retired<br>☐ Dependent<br>☐ Other *(Specify)* | Service<br>☐ US Air Force<br>☐ US Army<br>☐ US Marine Corps<br>☐ US Navy<br>☐ Other *(Specify)* | | Zip Code | Country |
| | | | Duty Phone<br>DSN:<br>Commercial | |
| | | | Duty Email | |
| Date of Birth *(mmddyy)* | End of Active Service *(mmddyy)* | | Emergency Contact *(Other than Spouse)* | |
| Home Street Address | Apartment | | Relationship | |
| City | State | | Phone | |
| Zip Code | Country | | Street Address | Apartment |
| Home Phone | | | City | State |
| Home Email | | | Zip Code | Country |
| Name of Eye Care Provider | | | Your Interests *(Check all that apply)*<br>☐ Aerobics ☐ Jogging ☐ Other *(Specify)*<br>☐ Biking ☐ Movies<br>☐ Hiking ☐ Reading<br>☐ Family ☐ Shopping | |
| Address | | | | |
| City | State | | | |
| Zip Code | Country | | Amount of time you spend wearing glasses or contact lenses for your distance vision:<br>☐ 0% ☐ 26-50% ☐ 76-100%<br>☐ < 25% ☐ 51-75% | |

What do you hope to achieve from having laser eye surgery? There can be no guarantee that glasses and contact lenses will no longer be necessary.

FOR OFFICIAL USE ONLY

**DEPARTMENT OF THE ARMY**
**WARFIGHTER REFRACTIVE EYE SURGERY PROGRAM**
**Bayne-Jones Army Community Hospital**
**Ft. Polk Louisiana**

MEMORANDUM FOR RECORD

SUBJECT: Patient briefing confirmation

I, *(name)*______________________________________________________, *(SSN)*________________________,
and *(PMOS/AOC)*________________ have been briefed on the policies and procedures for the Warfighter Refractive Eye Surgery Program at Bayne-Jones Army Community Hospital.

I acknowledge and understand that contact lenses cause the eye to swell, and that if they have not been removed for a sufficient period of time prior to the pre-op appointment and surgery **(30 days for soft lenses and 60 days for hard lenses)** they will impair the doctor's impression of the eye.

I have removed my contact lenses as of this date *(MMDDYY)*________________________.

I acknowledge and understand that if it is determined that I have worn my contact lenses at any time during the prescribed period leading up to my pre-op appointment my surgery appointment will be cancelled and I will be removed from the waiting list.

I acknowledge and understand that upon returning to Ft. Polk, I am required procure transportation to and from all postoperative appointments until the doctor has cleared me to drive.

I acknowledge and understand that it is my responsibility to notify the EENT clinic in the event that I may experience a scheduling conflict or an occurrence which may delay my arrival; that tardiness of more than 15 minutes is considered a missed appointment, and that failure to cancel pre-op and/or surgery appointments at least 24 hours in advance will result in my being removed from the program.

I acknowledge and understand my responsibility to keep all follow-up appointments scheduled with the EENT clinic during the 12 month evaluation period following my surgery, and that I must coordinate around my TDY and leave periods to be evaluated at these intervals: 1 day, 5 days, 1 month, 3 months, 6 months, and 12 months.

With my signature I acknowledge that I will comply with the rules set forth by the EENT clinic, and that a failure to do so may result in my being deemed ineligible for refractive eye surgery and possibly punishment under the UCMJ.

Patient Signature:____________________________________ Date: ______________________

# WARFIGHTER LASER SURGERY CENTER
# MANAGED CARE AGREEMENT

PATIENT NAME ______________________ SSN ______________________

SERVICE/STATUS ______________________ FORT/LOCATION ______________________

RANK ______________________ PHONE ______________________

## PATIENT AGREEMENT

I REQUEST TO BE RETURNED TO DR. SMITH ______________________ FOR POSTOPERATIVE CARE FOLLOWING REFRACTIVE SURGERY AT THE WARFIGHTER LASER SURGERY CENTER. I WILL NOT BE DEPLOYING IN THE NEXT 90 DAYS FOLLOWING SURGERY AND I WILL KEEP ALL OF MY POST OPERATIVE APPOINTMENTS. I KNOW THAT THE STAFF OF THE WARFIGHTER LASER SURGERY CENTER WILL BE AVAILABLE FOR ADDITIONAL CONSULTATION AS NEEDED.

PATIENT SIGNATURE ______________________ DATE ______________________

## REFERRING DOCTOR'S AGREEMENT

I AM QUALIFIED AND CAPABLE TO MANAGE THIS PATIENT AND I ACCEPT RESPONSIBILITY FOR HIS/HER POSTOPERATIVE CARE. I WILL SUBMIT ALL POSTOPERATIVE FOLLOW UP EXAMS TO THE TREATING WARFIGHTER LASER SURGERY CENTER. I ALSO AGREE TO REFER THIS PATIENT PROMPTLY IF A CONDITION PRESENTS POSTOPERTIVELY THAT WILL REQUIRE FURTHER TREATMENT BY THE WARFIGHTER LASER SURGERY CENTER - DSN 554-2010 or Fax 554-2313.

MINIMUM POSTOPERATIVE APPOINTMENT SCHEDULE 1 WEEK/1,2,3,4,6,AND 12 MONTHS

REFERRING OPTOMETRIST SIGNATURE ______________________ DATE ______________________

Benjamin Smith, MD MAJ, MC, USA OPHTHALMOLOGY
PRINT OR STAMP NAME, RANK

DSN 863-3276/3277
DUTY PHONE

FORT POLK, LA
FORT/LOCATION

863-3290
DUTY FAX

WILFORD HALL MEDICAL CENTER

Refractive Surgery Package Checklist

Name ______________________________ SSN ______________________________

Rank ______________________________ Fort ______________________________

Notes:

SRMC PRK/Lasik Authorization ______________________________

Commander's Authorization ______________________________

Managed Care Agreement ______________________________

Patient Info/History ______________________________

Duty Title ______________________________

Prior Rx – (over a year old) ______________________________

Manifest Refraction ______________________________

Cycloplegic Refraction ______________________________

Topography ______________________________

Orbscan ______________________________

Pachymetry (500-650) ______________________________

Slit Lamp/Fundus Exam ______________________________

Keratometry ______________________________

Date Contacts Discontinued? ______________________________

Type of Contacts Used? ______________________________

Date completed package given to laser center for review ______________________________

Date returned from laser center ______________________________

Evaluation Date ______________________________

Surgery Date ______________________________ Surgeon ______________________________

# VISX PRK OPERATIVE PLAN

Patient ______________________________ SSN ______________________________

______________________________ ______________________________

Allergies ______________________________ Age ______________________________

______________________________ ______________________________

Surgeon ______________________________ DOB ______________________________

**Verified Surgical Site:** ___________ **OD/OS/OU** Surgery Date ______________________________

| **OD** | | **OS** |
|---|---|---|
| __________ mm | Pupils (Ruler) | __________ mm |
| __________ mm | Pupils (Colvard) | __________ mm |
| Vas C 20/_______ Vas C 20/_______ | | Vas C 20/_______ Vas C 20/_______ |
| ________ + ________ x _________ | Manifest | ________ + ________ x _________ |
| ________ + ________ x _________ | Cycoplegic | ________ + ________ x _________ |
| ________ + ________ x _________ | Consensus/WS | ________ + ________ x _________ |
| ________ x _________ @ _________ | K's | ________ x _________ @ _________ |
| Pachs __________ | | Pachs __________ |

***Planned Treatment***

| **OD** | **OS** |
|---|---|
| ________ + ________ x _________ | ________ + ________ x _________ |

Large Blend

Large Blend

Epithelial Removal ☐ Brush ☐ Epi-Keratome ☐ Alcohol ☐ Other

Signed Informed Consent __________ *(Outpatient chart PRK chart)*

Signed Command Approval __________ *(PRK chart)*

Progress Note __________ *(Outpatient chart)*

Instructions / Post op Kit __________ *(To patient)*

Follow-up Appointments __________ *(To patient)*

Doctor's Signature ______________________________