REFRACTIVE SURGERY INFORMATION SHEET

ARMY APPLICATION

Joint Warfighter Refractive Surgery Center

1100 Wilford Hall Loop, Bldg 4554
JBSA Lackland AFB, TX 78236

Group email: USAF.JBSA.59-mdw.mbx.Warfighter-Refractive-Surgery-Center@mail.mil
Clinic Phone# (210) 292-4233 Fax# (210) 292-2313
Laser Center Phone# (210) 292-2237/2769 Fax# (210) 292-2813

Requirements for Warfighter candidates:

You must bring the following to our office, email or fax the required paperwork to be reviewed and scheduled for your initial evaluation.

1. **PRK Application:** Candidates must complete the entire application and be a minimum 21 years old to meet eligibility requirements to be considered for refractive surgery.
2. **Commander's Authorization:** Commanders signature is required for surgery.
3. **Eyeglass Prescription:** You will need to provide an eyeglass prescription that is **1-2 years old**. This will show if you have stability in your prescription. Bring glasses to your appt.

When you turn in this Packet!

**** Please discontinue your contact lens use****

Your initial evaluation will not be until your contacts have been removed for the specified amount of time

Soft Contacts - minimum of 30 days **Toric (hard) contacts** – minimum 30 days for every decade worn

For Patient Safety Reasons –

There are NO children allowed in the Clinic Or Surgery Center at Anytime

For more information: Follow us on Facebook

https:/www.facebook.com/warfighter 78236

Refractive Surgery Consult

Privacy Act Review

This statement serves to inform you of the purpose for collecting personal information as required in DHA Form 237.

AUTHORITIES: 5 U.S.C. 301, Department Regulation; 10 U.S.C., Chapter 55; Pub.L. 104-91, Health Insurance Portability and Accountability Act of 1996; DoD 6025.18-R, DoD Health Information Privacy Regulation; 10 U.S.C. 1071-1085, Medical and Dental Care; 42 U.S.C. Chapter 117, Sections 11131-11152, Reporting of Information; 10 U.S.C.1097a and 1097b, TRICARE Prime and TRICARE Program; 10 U.S.C. 1079, Contracts for Medical Care for Spouses and Children; 10 U.S.C. 1079a, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); 10 U.S.C.1086, Contracts for Health Benefits for Certain Members, Former Members, and Their Dependents; DoD Instruction 6015.23, Delivery of Healthcare at Military Treatment Facilities (MTFs); DoD 6010.8-R, CHAMPUS; 10 U.S.C. 1095, Collection from Third Party Payers Act; and E.O. 9397 (SSN).

PURPOSE: DHA Form 237 is used to collect information on active-duty service members applicants and will be used to determine medical and administrative eligibility for elective ocular surgeries. Applicants will complete the form and submit the form through email to the closest Warfighter Refractive Eye Surgery Program ("WRESP") for review and potential action.

ROUTINE USES: Information in your records may be disclosed to private physicians and Federal agencies, including the Departments of Veterans Affairs, Health and Human Services, and Homeland Security in connection with your medical care; other federal, state, and local government agencies to determine your eligibility for benefits and entitlements and for compliance with laws governing public health matters; and government and nongovernment third parties to recover the cost of healthcare provided to you by the Military Health System. Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: EDHA 07, "Military Health Information System" (November 18, 2013, 78 FR 69076)
https://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570672/edha-07/.

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay in authorizing your care, but care will not be denied.

SECTION 1.

LAST NAME:	UNIT:
FIRST NAME:	UNIT ZIP:
GRADE:	WORK TEL:
ON FLIGHT STATUS:	MOBILE TEL:
UNIT DESIGNATOR:	MOS/AFSC/NEC/Job
DOB: *(YYYYMMDD)*	CURRENT DUTY STATION AND STATE:
AGE:	PROJECTED ROTATION DATE: *(YYYYMMDD)*
DOD ID:	CURRENT END OF ACTIVE DUTY COMMITMENT: *(YYYYMMDD)*
HOME EMAIL:	
WORK EMAIL:	
REQUESTED TREATMENT FACILITY:	
FACILITY INFORMATION:	YOUR MILITARY BRANCH: / OTHER: *(please specify)*
	SERVICE TYPE:
	Have you had refractive surgery before?
	Are you pregnant or nursing?
	Have you or a family member been diagnosed with Keratoconus?

SECTION 2. Command Authorization (please see instructions on page 2)

USA/USAF must have > 6 months remaining on active duty on day of surgery
NAVY/USMC/USCG must have > 12 months remaining on active duty on day of surgery

Deploying within 6 Months: ☐ No ☐ Yes	SM's Priority Level (see instructions: ☐ 1 ☐ 2 ☐ 3 ☐ 4
Is patient on limited duty and/or subject to a physical evaluation board? ☐ Yes ☐ No	Do you approve for this SM to have refractive surgery?
	Service information has been validated.
Full Name of Commanding Officer:	RANK:
	SIGNATURE & DATE:
PHONE NUMBER:	EMAIL:

LAST NAME:	FIRST NAME:

SECTION 3. Professional Recommendation: (to be completed by Optometrist/Ophthalmologist)

PROVIDER'S LAST, FIRST NAME:	SIGNATURE:	
CLINIC TEL: *(include area code)*	LOCATION:	
DATE OF EYE EXAMINATION: *(YYYYMMDD)*	PROVIDER EMAIL:	

UCDVA		>1 Yr. MRx:	Sphere	Cylinder		Axis
OD: 20/		OD:			X	
OS: 20/		OS:			X	

CRx:	Sphere	Cylinder		Axis	VA 20/
OD:			X		
OS:			X		

VERIFICATION: *Check all that apply*		
	☐ ≤ 0.50D change in sphere or cylinder in last 12 mos.	☐ Dry eyes, blepharitis managed
	☐ RGP wear: consider refit into soft daily wear CL	☐ Soft extended wear: must go to daily wear

COMMENTS:

Universal Warfighter Refractive Eye Surgery Program (WRESP) Application Instructions

1. To submit application, scan and email completed form to closet WRESP Center via their group mailbox in Section 1. You will receive confirmation via email within30 days. If you do not receive a confirmation email within 30 days or need to make an update to your contact information or have questions send an email and call the WRESP center. This form covers the required NAVMED data fields and requirements. All SMs will go through a thorough medical screening by WRESP staff to validate medical eligibility.

2. Guidance to unit commanders for processing requests for corneal refractive surgery (CRS).

   a. This is a program only intended for service members (SMs) on active duty (AD) orders and meets time-in-service (TIS) requirements set by SM's service component regulations.

   b. CRS procedures (PRK - LASIK – SMILE - ICL) are elective ocular surgeries to reduce or eliminate the need for distance vision correction and enhance the readiness of SMs who are medically and administratively qualified.

   c. Commander's approval; by signing the refractive surgery consult form, they give their permission and verify:

      (1) The SM can be considered for enrollment in the WRESP, and for treatment, and meets *AD TIS requirements for this surgery.

      (2) The SM, neither, has any adverse personnel action, nor, pending a medical evaluation board or physical evaluation board.

      (3) SM may have to remain CONUS and is NON-Deployable for up to 90 days post-surgery (PRK: 90 days; LASIK/SMILE/ICL/RLE: 30 days). In rare cases, time can be longer.

      (4) After CRS the SM will be on CONVALESCENT LEAVE for 7 to 14 days and will have a PHYSICAL PROFILE/LIGHT DUTY condition for a minimum of 30 days, but can be longer, in < 10% of patients. More recovery time may be needed if ICL and refractive lens exchange are done. A month follow-up will needed with no deployments during that time.

      (5) They acknowledge the SM is required to complete FOLLOW-UPS at 1, 3, and 6 months, with the possibility of 12-months or higher. If SM is deploying/ separating from service before the 6-month exam is due, they are required to complete the 1- and 3-month exams and then return to for a post-operative exam at the completion of their deployment or before separation.

      (6) WRESP centers may conduct medical studies. If so, additional information will be provided to service members prior to participation, **if eligible.

3. Referring Provider's Instruction.

   a. The referring provider will complete a full ocular exam to include but not limited to: corneal thickness/pachymetry (if possible), and corneal topography/tomography (if available). Physician will assure there is a stable Rx of more than one year to compare to ">1 yr MRx" in Section 3 and make a statement to that effect in the comments box.

   b. Comments pertaining to Pachs and Topos (Normal/Abnormal) will be added to the in the comments block in Section 3.

(Continued on Page 3)

LAST NAME:	FIRST NAME:

4. **Treatment priorities** for USN, USMC, and USCG.

   a. **Priority 1 (High Priority).** SM's job requires them to frequently and regularly work in an extreme physical environment that precludes the safe use of spectacles or contact lenses. SM has an unusually physically demanding and dangerous job. Probability of survival would clearly be enhanced with this procedure. (Examples: aviators/EOD/Special Forces, Combat Arms Deploying within 6 Months).

   b. **Priority 2.** SM's job requires them to frequently and regularly work in a physical environment where spectacle or contact lens use is possible and would not compromise personal safety or jeopardize completion of the mission, but where their use is physically more difficult or challenging. NOT a safety or survivability issue. Procedure is likely to enhance job performance. High priority, but not absolutely imperative. (Example: Security Forces, military duties include use of NVG, or respiratory masks or Marines not in Category I)

   c. **Priority 3.** SM is not typically exposed to environmental extremes or physical activity or use of equipment precluding use of spectacles or contact lenses, but may on occasion, qualify for Category II.

   d. **Priority 4.** SM's job rarely or ever exposes them to extreme conditions, physical activity, or use of special equipment where performance would be diminished by use of glasses or contact lenses.
   (Example: administrative, clerical, office work in an indoor, non-extreme environment)

* It is ultimately the Commander's responsibility to validate and confirm all regulatory requirements for AD TIS are met.

** WRESP centers may conduct medical studies. If so, full disclosure will be made to SM and commander.

REFRACTIVE SURGERY PATIENT HISTORY

The collection of information is governed by the Authority, Purpose and Routine Uses Identified in DD Form 2005, Privacy Act Statement - Health Care Records.

1. PATIENT NAME (Last, First, MI)	2. DATE	3. DOD CAC ID

REFRACTIVE HISTORY

4. How many years have you worn glasses?	5. How many years have you worn contact lenses?	6. How old is your current glasses prescription?

7. When did you last wear contact lenses?	8. Do you or have you ever worn bifocals?	9. Have you ever had difficulty with contact lens wear? Describe

10. CONTACT LENS TYPE: ☐ Soft ☐ Rigid Brand: _____

11. ALLERGIES Do you have any allergies to medications? ☐ NO ☐ YES

Please list medication and reaction. _____

12. OCULAR SURGERY Have you ever had surgery or laser treatments on your eyes? ☐ NO ☐ YES

Specify _____

13. OCULAR HISTORY Do you have any of the following eye problems?

Amblyopia/Lazy Eye	☐ NO ☐ YES	Cataracts	☐ NO ☐ YES	Conjunctivitis, recurrent	☐ NO ☐ YES
Corneal Ulcer	☐ NO ☐ YES	Double Vision	☐ NO ☐ YES	Dry Eyes	☐ NO ☐ YES
Glaucoma or High Eye Pressure	☐ NO ☐ YES	Herpes Simplex/Zoster	☐ NO ☐ YES	Keratoconus	☐ NO ☐ YES
Retinal Problems	☐ NO ☐ YES	Trauma	☐ NO ☐ YES		
Other	☐ NO ☐ YES Specify _____				

14. MEDICAL HISTORY Do you or have you ever had the following?

Arthritis	☐ NO ☐ YES	Breathing Problems	☐ NO ☐ YES	Diabetes	☐ NO ☐ YES
Heart Problems	☐ NO ☐ YES	High Blood Pressure	☐ NO ☐ YES	Migraine Headaches	☐ NO ☐ YES
Pacemaker	☐ NO ☐ YES	Immunosuppression/HIV	☐ NO ☐ YES		
Other Medical Problems	☐ NO ☐ YES Specify _____				

15. MEDICATIONS Are you taking any of the following?

Accutane (Isotretinoin)	☐ NO ☐ YES	Birth Control Pills	☐ NO ☐ YES	Cordarone (Amiodarone)	☐ NO ☐ YES
Immunosuppressants	☐ NO ☐ YES	Imitrex (Sumatriptan)	☐ NO ☐ YES	Steroid Medication	☐ NO ☐ YES

List other medications you are currently taking: _____

16. PATIENT SIGNATURE	17. DATE

18. TECHNICIAN COMMENTS Web Sites Provided ☐ NO ☐ YES VISX Booklet Provided ☐ NO ☐ YES Consent Form Provided ☐ NO ☐ YES

Convalescent Leave Form Provided ☐ NO ☐ YES

19. TECHNICIAN NAME (Last, First, MI)	20. TECHNICIAN SIGNATURE	21. DATE

22. PHYSICIAN COMMENTS

23. PHYSICIAN NAME (Last, First, MI)	24. PHYSICIAN SIGNATURE	25. DATE

26. FOR OFFICIAL USE ONLY

WILFORD HALL AMBULATORY SURGICAL CENTER REFRACTIVE SURGERY PATIENT INFORMATION

The collection of information is governed by the Authority, Purpose and Routine Uses Identified in DD Form 2005, Privacy Act Statement - Health Care Records.

1. PATIENT NAME (Last, First, MI)	2. OCCUPATION	3. AFSC	4. DATE

5. GRADE	6. MARITAL STATUS	7. DOD CAC ID	8. DATE OF BIRTH (MM/DD/YY)	9. SEX ☐MALE ☐FEMALE

10. DUTY ADDRESS (City, State, Zip Code, Country)

11. DUTY PHONE (DSN)	12. DUTY PHONE (Commercial)	13. DUTY EMAIL

14. STATUS
☐Active Duty ☐Reserve ☐Retiree ☒Dependent ☐Other _____

15. SERVICE
☐Air Force ☐Army ☐Navy ☐Marine Corps ☐Other _____

16. END OF ACTIVE SERVICE (MM/DD/YYYY)

17. HOME STREET ADDRESS (Apartment Number if applicable)	18. CITY	19. STATE

20. ZIP CODE	21. COUNTRY	22. HOME PHONE	23. HOME EMAIL

24. EMERGENCY CONTACT (Other than spouse)	25. RELATIONSHIP	26. PHONE

27. HOME STREET ADDRESS (Apartment Number if applicable)	28. CITY	29. STATE	30. ZIP CODE	31. COUNTRY

32. NAME OF EYE CARE PROVIDER	33. ADDRESS	34. CITY

35. STATE	36. ZIP CODE	37. COUNTRY	38. PHONE

39. YOUR INTERESTS (Check all that apply.)
☐Aerobics ☐Biking ☐Hiking ☐Family ☐Jogging ☐Movies ☐Reading ☐Shopping ☐Other _____

40. Amount of time you spend wearing glasses or contact lenses for your DISTANCE vision. ☐0% ☐< 25% ☐26-50% ☐51-75% ☐75-100%

41. 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.

42. FOR OFFICIAL USE ONLY

REFRACTIVE SURGERY MANAGED CARE AGREEMENT

The collection of information is governed by the Authority, Purpose and Routine Uses Identified in DD Form 2005, Privacy Act Statement - Health Care Record

1. PATIENT NAME (Last, First, MI)	2. RANK	☐ USAF ☐ USA ☐ USN ☐ USMC ☐ USCG ☐ USPHS ☐ NOAA
3. MILITARY INSTALLATION	4. PHONE	5. E-MAIL

6. In the next 6 months are you: ☐ PCSing ☐ Separating ☐ Retiring ☐ Deploying ☐ N/A

7. Refractive Surgery Center: ☐ Joint Warfighter, Lackland AFB ☐ USAF Academy ☐ Wright-Patterson AFB ☐ Keesler AFB ☐ Travis AFB ☐ Joint Base Elmendorf/Richardson ☐ Andrews AFB ☐ Other DoD _____

PATIENT AGREEMENT (After reading and understanding, initial each statement.)

_____ I request to be returned to my local eye clinic for post-operative care following refractive surgery at the DoD Refractive Surgery Center listed above. The Refractive Surgery Center staff will be available for additional consultation as needed.

_____ I will contact my local Optometry Clinic to schedule my first follow-up appointments as soon as I am notified of my surgery date.

_____ I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by USAF policy. Non-compliance may result in duty restrictions or disqualification.

_____ I will contact my local Optometry Clinic or Primary Care Manager within 3 days of receiving treatment. I am aware that I will be placed on Duty Limiting Condition status after surgery and cannot deploy or PCS for up to 4 months after surgery. I understand that I must be evaluated by the base optometry clinic prior to being cleared to resume unrestricted duties.

_____ I understand that I must bring the package of all pre-operative evaluations, surgical reports, and follow-up exams provided by the Refractive Surgery Center to my local optometry clinic for inclusion in my military medical records.

8. PATIENT SIGNATURE	9. DATE

POST-OPERATIVE APPOINTMENT SCHEDULE:
AASD: 1, 3, 6, 12, and as required for waiver renewal.
Warfighter: 1, 3, 6, 12 months
Note: ASA(PRK, LASEK, Epi-LASIK, WFG-PRK) requires a 2 month pressure check.

REFERRING DOCTOR'S AGREEMENT
I certify that I have attended the USAF-CRS Co-Management Course. I will manage this patient and accept responsibility for his/her post-operative care. I agree to refer this patient promptly if a condition arises post-operatively that will require further treatment by the Refractive Surgery Center. I will assure that I am able to provide post-operative care until the expiration date provided below.

10. REFERRING OPTOMETRIST STAMP	11. OPTOMETRIST SIGNATURE	12. CO-MANAGEMENT EXPIRATION DATE (Not to exceed one year from exam date

13. MILITARY INSTALLATION	14. PHONE	15. FAX	16. E-MAIL

AUoF / PRP CONSENT FORM

AUoF: ☐YES ☐NO PRP: ☐YES ☐ NO

(Do You Carry A Weapon)
ARMED USE OF FORCE

(Work with Nuclear Weapons)
PERSONNEL RELIABILITY PROGRAM

FLYING STATUS: ☐ YES ☐ NO
Actively Flying or not makes no difference

RESERVES or NAT'L GUARD: ☐ YES ☐ NO

RELEASE AND CONSENT FOR OCULAR IMAGING DIAGNOSTIC TESTING

I hereby authorize images to be taken for medical purposes. I agree to the use of the negatives, prints, copies or reproductions for insurance documentation, monitoring my condition, for teaching, and for publication for educational purposes.

*****IMPORTANT INFORMATION*****

PLEASE READ THE FOLLOWING INFORMATION AND SIGN THAT YOU ACKNOWLEDGE:

**Your appointment may last 2-3 hours. You will be dilated. The dilation may last 2-3 hours. There are NO children allowed in our clinic or Surgery center. It is up to you to bring a driver if you are not comfortable driving. It is NOT mandatory as this is an Elective surgery.

_____ _____

Signature **Date:**