-Ophthalmology-
Refractive Surgery

Name:_____ Rank: _____

SSN:_____

Phone # (primary) _____ Alternate: _____

Unit:_____

Email (Military):_____

ETS Date:_____

Command Auth Date:_____

Please attach the following before turning in your packet:

-most recent ERB
-eye glass prescription older than 1 year (no older than 7 years)

For Internal Use Only

Date Contacted: _____

Scans: _____

Pachs: <

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 your phone number as the first line of communication please make sure that the phone number you provide is one that you regularly use.

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

4. YOU MUST BE OUT OF CONTACT LENSES FOR **AT LEAST 30 DAYS** PRIOR TO ANY EVALUATIONS AND CONTINUE TO STAY OUT OF THEM FOR SURGERY.

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 the answer.
    - ***Managed Care Agreement:*** Needs to be filled out and signed by you as the patient. Do not worry about the Physicians signature at this time.

6. A complete local packet includes the following (please do not include a copy of these instructions):
    1. Completed and dated *PRK/LASIK Application* Form
    2. Signed and dated *Commander's Authorization* Letter
    3. Completed, dated, and signed *Patient History Questionnaire* Form
    4. Signed *Managed Care Agreement* by you, the patient
    5. **Eye prescription Older than one year**

7. Submit the complete packet to:
    EENT front desk - call the EENT front desk 337-531-3276/3277 for any questions regarding your packet.

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.***
6. *Incomplete forms will not be accepted and will not be submitted until all information is completed. 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
Evans Army Community Hospital	Fort Carson, Colorado Springs, CO
Irwin Army Community Hospital	Fort Riley, Kansas

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

SSN: no dashes	Date of Birth: dd/mon/yyyy	Age:	Sex: ☐Male ☐Female	AOC/ 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:

☐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 SRMC 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 SRMC 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:

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: _____ **Date of Separation:** _____ MOS/AOC: _____ **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 Deploy TDY 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.

Company Commanders Signature	Battalion Commanders Signature
Company Commanders Name and Rank	Battalion Commanders Name and Rank
Date / Phone	Date / Phone
Company Commanders Email Address	Battalion Commanders 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)

Additional Comments:

PATIENT SIGNATURE:_____

TO BE COMPLETED BY THE WARFIGHTER LASER CENTER STAFF:

SURGERY TECHNICIAN COMMENTS	SURGERY PHYSICIAN COMMENTS
Technician Signature:_____	

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)*

Warfighter Refractive Eye Surgery Program

Managed Care Agreement

☐USAF ☐USA ☐USN ☐USMC
☐USCG ☐USPHS ☐NOAA

Patient Name _____ Rank _____

Fort Polk, LA
Military Installation _____ Phone _____ E-mail _____

In the next 6 months, are you: ☐PCSing ☐Separating ☐Retiring ☐Deploying ☐N/A ☐None

Refractive Surgery Center: ☐ Joint Warfighter, Lackland AFB

PATIENT AGREEMENT

I REQUEST TO BE RETURNED TO **BJACH Optometry-Fort Polk** 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 _____

Minimum Post-Operative Appointment Schedule:

Completed at treating surgery center: 1-day
Completed at local eye clinic: 5-7-day, 1, 3, 6, 12 months

REFERRING DOCTOR'S AGREEMENT

I certify that 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.

Referring Optometrist Stamp/Signature _____ Date _____

Fort Polk | 337-531-3276/77 | 337-531-3290 | _____
Military Installation | Phone | Fax | E-mail

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: _____

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 _____