

Requirements for Warfighter candidates, if you are an AF Aviator do not use these forms, please request the AASD forms:

Email your application to the org box address below. This helps us keep track of all applications and ensures we read each one thoroughly.

usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@health.mil

****RETAINABILITY QUALIFICATIONS****

Air Force and Army - within six months of your potential surgery date

Navy, Marines, and Coast Guard - within one year.

Active Guard Reservists and National Guardsmen must provide a copy of their active duty orders.

Candidates must be a minimum of 21 years to meet eligibility required to be considered for refractive surgery.

Please provide a date of separation or end of active duty commitment, per the surgeon general. We cannot accept 'N/A' or 'indefinite'

Are you pregnant or nursing? You'll need to wait 6 months after pregnancy or nursing to apply.

Require Tab 1 & 2. If your application is not complete, it will be placed on hold until we receive all documentation.

Tab 1 - DHA_237 Oct 2024

Tab 2 – Supplemental Forms – Local (non-flyer)

Our admin team will gather all other information needed for clinical review, if we are not able to retrieve any information that is needed we will reach out by phone or email. Clinical review will take 2-3 weeks. After clinical review, your application may require additional review by a surgeon, which can take an additional week or two depending on their schedule. You will be contacted via email or phone call once a decision has been made.

No appointments will be scheduled until your application is reviewed and approved to move forward.

We appreciate your patience and if you have any questions, please do not hesitate to reach out.

REQUEST FOR REFRACTIVE SURGERY CONSULTATION

Privacy Act Statement

AUTHORITIES: Public Law 117-81, National Defense Authorization Act for Fiscal Year 2022, Section 732, Treatment of Anomalous Health Conditions; 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C., Chapter 55, Medical and Dental Care; Department of Defense (DoD) Instruction 6015.23, Foreign Military Personnel Care and Uniform Business Offices in Military Treatment Facilities (MTFS); DoD Manual (DoDM) 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs;" and E.O. 9397 (SSN), as amended.

PURPOSE: The DHA Form 237 collects info from service members applying for refractive surgery. Applicants must submit the completed form via email to a Warfighter Refractive Eye Surgery Program (WRESP) Center. The info will be used to determine eligibility for an in-person surgery evaluation at the WRESP Center.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies (including the Departments of Veterans Affairs, Health and Human Services, and Homeland Security for members of the Coast Guard) in connection with your medical care, government agencies to determine your eligibility for benefits and entitlements, government and nongovernment third parties to recover the cost of Military Health System (MHS) provided care, public health authorities to document and review occupational and environmental exposure data, and government and nongovernment organizations to perform DoD-approved research. For a complete listing of the routine uses, see the below hyperlinked SORN.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, 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 (June 15, 2020; 85 FR 36190)
<https://dpclid.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf>

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but the MHS may be unable to provide you with comprehensive healthcare.

SECTION 1. Applicant Information (to be completed by applicant, per instructions on page 3).

LAST NAME:	UNIT:	UNIT ZIP:
FIRST NAME:	WORK TEL:	
GRADE:	MOBILE TEL:	
ON FLIGHT STATUS:	MOS/AFSC/NEC/Job:	
UNIT DESIGNATOR:	CURRENT DUTY STATION AND STATE:	
DOB (YYYYMMDD):	PROJECTED CHANGE OF STATION DATE (YYYYMMDD):	
AGE:	CURRENT END OF ACTIVE DUTY COMMITMENT (YYYYMMDD):	
DOD ID:		
HOME EMAIL:		
WORK EMAIL:		
REQUESTED TREATMENT FACILITY:	YOUR MILITARY BRANCH:	OTHER (please specify):
FACILITY INFORMATION:	SERVICE TYPE:	
	Have you had refractive surgery before?	
	Are you pregnant or nursing (currently or in past 6 months)?	
	Have you or a family member been diagnosed with keratoconus, pellucid, or ectasia?	
	PATIENT NAME:	
	PATIENT SIGNATURE:	DATE:

SECTION 2. Commander's Authorization (to be completed by the applicant's Commander, per instructions on page 3).

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

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

LAST NAME:					FIRST NAME:									
SECTION 3. Referring Doctor's Recommendation (to be completed by optometrist/ophthalmologist, per instructions on page 3).														
PROVIDER'S LAST, FIRST NAME:					SIGNATURE:									
CLINIC TEL (include area code):					LOCATION:									
DATE OF EYE EXAMINATION (YYYYMMDD):					PROVIDER EMAIL:									
MRx Date:				CRx Date:				Contacts		UDVA		Pachymetry		
	Sphere	Cylinder	Axis	CDVA		Sphere	Cylinder	Axis	CDVA	Date last worn:		OD: 20/		OD:
OD:				20/	OD:				20/	Type (soft v. hard):		OS: 20/		OS:
OS:				20/	OS:				20/					
MRx Older Than 1 Year Date:					VERIFICATION (each statement must be verified):									
	Sphere	Cylinder	Axis	CDVA	<input type="checkbox"/> ≤ 0.50D change in sphere or cylinder in last 12 months									
OD:				20/	<input type="checkbox"/> Pentacam or topography attached and uploaded to electronic medical record									
OS:				20/	<input type="checkbox"/> No dry eyes/blepharitis or dry eyes/blepharitis managed									
Co-Management Agreement Between Patient and Co-Managing Doctor (for patients requesting to complete post-operative care at a facility other than the WRESP Center where the surgery will be performed).														
Patient's Agreement														
<p>I wish to pursue post-operative care at my local Optometry Clinic instead of the WRESP Center where my surgery is performed. I understand that I may return to the WRESP Center for consultation as needed. I will contact my local Optometry Clinic to schedule my post-operative months 1, 3, 6, and 12 follow up appointments as soon as I am notified of my surgery date. The WRESP Center may deny me surgery if I have not scheduled my follow up appointments. I understand that I must complete all required follow up appointments. I am aware that I will be placed on "Duty Limiting Condition" status after surgery. I understand that I cannot deploy or PCS for at least 30 to 90 days (60-90 days for PRK, 30 days for LASIK/SMILE/ICL/RLE), and this mobility restriction may be extended depending on my healing. I understand that I must be evaluated by my local Optometry Clinic prior to being cleared to resume unrestricted duties, PCS, or deploy.</p>														
PATIENT NAME (Last, First):					PATIENT SIGNATURE:									
Co-Managing Doctor's Agreement														
<p>I agree that I will manage this patient and accept responsibility for the SM's post-operative care. Post-operative appointments will be scheduled at 1, 3, 6, and 12 months. If the SM is deploying before the 6-month exam, then the SM will complete the 3-month exam and return for a post-operative exam at the completion of the SM's deployment. I will transmit, via the electronic medical record, the results of each post-operative exam to the WRESP Center that performed the patient's surgery. I will do this for one year post-operatively or until there is resolution of any complications - whichever is later. I agree to refer this patient promptly if a condition arises post-operatively that will require further treatment by the WRESP Center. I certify that I can provide post-operative care until the expiration date provided below.</p>														
I certify that I have attended the USAF-CRS Co-Management Course (required only if managing an Air Force SM).														
EXPIRATION DATE:		PROVIDER NAME (Last, First):			PROVIDER SIGNATURE:									
COMMENTS:														

LAST NAME:

FIRST NAME:

Universal Warfighter Refractive Eye Surgery Program (WRESP) Application Instructions

1. Guidance for SM Applicants

- a. The SM will complete all components listed in Section 1.
- b. After Section 1 is complete, the SM will submit this form to the SM's Commander for completion of Section 2.
- c. After Section 2 is complete, the SM will review the Co-Management Agreement in Section 3 and sign if applicable. The SM will then contact the SM's local Optometry or Ophthalmology Office for completion of Section 3. This requires an examination at the local Optometry/Ophthalmology Office.
- d. After Section 3 is complete, the SM will email the completed DHA Form 237 to the WRESP Center via the email listed in the "Facility Information" box in Section 1. The WRESP Center will respond to the SM's application within 30 days. If the SM has not received an application status update within 30 days, the SM should email and/or call the WRESP Center. The SM is expected to keep the SM's contact information up-to-date with the WRESP Center. After review of the patient's application, the WRESP Center will determine the patient's eligibility for a refractive consultation at the WRESP Center. SMs who pass the necessary criteria during consultation may be offered refractive surgery.
- e. The SM must inform the WRESP Center of any of the following, should they occur between the time that DHA Form 237 is signed by the Commander and the SM's refractive surgery date.
 - (1) Any adverse personnel actions involving the SM.
 - (2) Placement of the SM on a medical profile/limited duty status.
 - (3) Initiation of a medical/physical evaluation board for the SM.

2. Guidance for Commanders

- a. Refractive surgeries (PRK/LASIK/SMILE/ICL/RLE) 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 for surgery. The Warfighter Refractive Eye Surgery Program is only intended for SMs on active duty (AD) orders who meet time-in-service (TIS) requirements set by the SM's service component regulations.
- b. SMs are assigned different Priority levels for surgery, depending upon the SM's job.
 - (1) Priority 1 (High Priority). SM's job requires SM 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 refractive eye surgery. Examples include Aviators, Explosive Ordnance Disposal Personnel, Special Forces, or Combat Arms deploying within 6 months.
 - (2) Priority 2. SM's job requires SM 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 the use of spectacles or contact lenses is physically more difficult or challenging. NOT a safety or survivability issue. Procedure is likely to enhance job performance. Examples include Security Forces or SMs using night vision goggles or respiratory masks.
 - (3) Priority 3. SM is typically not exposed to environmental extremes, physical activity, or use of special equipment where performance would be diminished by use of spectacles or contact lenses.
- c. For the SM to be considered for the WRESP, the SM must obtain authorization from the SM's Commander via Section 2 of DHA Form 237. Commanders are asked to complete all components of Section 2.
- d. By signing DHA Form 237:
 - (1) Commanders are verifying (a) that the SM meets AD TIS requirements for this surgery, (b) the SM does not have any adverse personnel action, (c) is not on a medical profile/limited duty status, and (d) and is not pending a medical/physical evaluation board. It is recommended that Commanders, or their representatives, contact the servicing WRESP Center for the projected surgery time frame, to calculate if SM meets TIS requirements.
 - (2) Commanders commit to informing the WRESP Center of any of the following, should they occur between the time that DHA Form 237 is signed by the Commander and the SM's refractive surgery date.
 - (a) Any adverse personnel actions involving the SM.
 - (b) Placement of the SM on a medical profile/limited duty status.
 - (c) Initiation of a medical/physical evaluation board for the SM.
 - (3) Commanders also express their commitment to supporting the SM through the following post operative requirements and restrictions:
 - (a) The SM will be on convalescent leave for up to 7 days following surgery. This is independent of travel time to and from the WRESP Center.
 - (b) The SM will be placed on a "physical profile" and restricted to "light duty" conditions 30- 90 days post-surgery (LASIK/SMILE/ICL/RLE: 30 days; PRK: 60-90 days), sometimes longer based on variations in healing times.
 - (c) The SM may have to remain CONUS and is INELIGIBLE for change of station or deployment for 30- 90 days post-surgery (LASIK/SMILE/ICL/RLE: 30 days; PRK: 60-90 days), sometimes longer based on variations in healing times.
 - (4) The SM is required to complete follow up appointments at 1, 3, and 6 months, with the possibility of 12-months or longer. If the SM is deploying before the 6-month exam is due, then the SM is required to complete the 1- and 3-month exams, and then return for a post-operative exam at the completion of the SM's deployment.
 - (5) WRESP Centers may conduct medical studies. If so, additional information will be provided to the SM and the SM's Commander prior to participation.

3. Guidance for Referring Doctors

- a. For the SM to be considered for the WRESP, the SM must schedule a screening exam with an optometrist or ophthalmologist.
- b. The referring doctor will complete all components of Section 3 "Referring Optometrist/Ophthalmologist Recommendation." Any abnormalities in the patient's exam, Pentacam, or topography will be noted in the "Comments" box in Section 3.
- c. If the applicant is desiring co-management post-operatively, then the SM and the co-managing optometrist/ophthalmologist are required to sign the "Co-Management Agreement" in Section 3. If co-managing an AF SM, the co-managing doctor must have completed the CRS Co-Management Course via the Military Refractive Surgery Safety and Standards Symposium or via the options outlined at usafsam.geniussis.com/Registration.aspx.

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
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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?
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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
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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 <input type="checkbox"/> NO <input type="checkbox"/> YES	Cataracts <input type="checkbox"/> NO <input type="checkbox"/> YES	Conjunctivitis, recurrent <input type="checkbox"/> NO <input type="checkbox"/> YES
Corneal Ulcer <input type="checkbox"/> NO <input type="checkbox"/> YES	Double Vision <input type="checkbox"/> NO <input type="checkbox"/> YES	Dry Eyes <input type="checkbox"/> NO <input type="checkbox"/> YES
Glaucoma or High Eye Pressure <input type="checkbox"/> NO <input type="checkbox"/> YES	Herpes Simplex/Zoster <input type="checkbox"/> NO <input type="checkbox"/> YES	Keratoconus <input type="checkbox"/> NO <input type="checkbox"/> YES
Retinal Problems <input type="checkbox"/> NO <input type="checkbox"/> YES	Trauma <input type="checkbox"/> NO <input type="checkbox"/> YES	
Other <input type="checkbox"/> NO <input type="checkbox"/> YES	Specify _____	

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

Arthritis <input type="checkbox"/> NO <input type="checkbox"/> YES	Breathing Problems <input type="checkbox"/> NO <input type="checkbox"/> YES	Diabetes <input type="checkbox"/> NO <input type="checkbox"/> YES
Heart Problems <input type="checkbox"/> NO <input type="checkbox"/> YES	High Blood Pressure <input type="checkbox"/> NO <input type="checkbox"/> YES	Migraine Headaches <input type="checkbox"/> NO <input type="checkbox"/> YES
Pacemaker <input type="checkbox"/> NO <input type="checkbox"/> YES	Immunosuppression/HIV <input type="checkbox"/> NO <input type="checkbox"/> YES	
Other Medical Problems <input type="checkbox"/> NO <input type="checkbox"/> YES	Specify _____	

15. MEDICATIONS Are you taking any of the following?

Accutane (Isotretinoin) <input type="checkbox"/> NO <input type="checkbox"/> YES	Birth Control Pills <input type="checkbox"/> NO <input type="checkbox"/> YES	Cordarone (Amiodarone) <input type="checkbox"/> NO <input type="checkbox"/> YES
Immunosuppressants <input type="checkbox"/> NO <input type="checkbox"/> YES	Imitrex (Sumatriptan) <input type="checkbox"/> NO <input type="checkbox"/> YES	Steroid Medication <input type="checkbox"/> NO <input type="checkbox"/> YES

List other medications you are currently taking: _____

16. PATIENT SIGNATURE	17. DATE
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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
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22. PHYSICIAN COMMENTS

23. PHYSICIAN NAME (Last, First, MI)	24. PHYSICIAN SIGNATURE	25. DATE
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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 <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
10. DUTY ADDRESS (City, State, Zip Code, Country)									
11. DUTY PHONE (DSN)			12. DUTY PHONE (Commercial)			13. DUTY EMAIL			
14. STATUS <input type="checkbox"/> Active Duty <input type="checkbox"/> Reserve <input type="checkbox"/> Retiree <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____									
15. SERVICE <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> 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.) <input type="checkbox"/> Aerobics <input type="checkbox"/> Biking <input type="checkbox"/> Hiking <input type="checkbox"/> Family <input type="checkbox"/> Jogging <input type="checkbox"/> Movies <input type="checkbox"/> Reading <input type="checkbox"/> Shopping <input type="checkbox"/> Other _____									
40. Amount of time you spend wearing glasses or contact lenses for your DISTANCE vision. <input type="checkbox"/> 0% <input type="checkbox"/> < 25% <input type="checkbox"/> 26-50% <input type="checkbox"/> 51-75% <input type="checkbox"/> 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									

Special Circumstances

Answer yes or no to each prompt.

	Yes	No
Armed Use of Force (AUoF) (Do you carry a weapon?)		
Personnel Reliability Program (PRP) (Do you work with nuclear weapons?)		
Are you on Flying Status?		
Are you in the Reserves or National Guard?		

Patient's Agreement

Follow Up Care Requirements

I understand that I must complete all required follow up appointments after surgery. At a minimum, these will take place 1 day, 1 week, 1 month, 3 months, 6 months, and 12 months after surgery. I understand that these appointments may be with my surgeon or with another doctor on the Refractive Surgery Team.

I am aware that I will be placed on "Duty Limiting Condition" status after surgery. I understand that I cannot deploy or PCS for at least 30 to 90 days (60-90 days for PRK, 30 days for LASIK/SMILE/ICL/RLE), and this mobility restriction may be extended depending on my healing. I understand that I must be evaluated by the Refractive Surgery Clinic prior to being cleared to resume unrestricted duties, PCS, or deploy.

Release and Consent for Ocular Imaging and 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 of my condition, teaching, and publication for educational purposes.

Anticipatory Guidance

I understand that my appointment may last 2-3 hours. I will be dilated. The dilation may last 24-72 hours. I need to bring a driver if I suspect I will not be comfortable driving while dilated. On the day of surgery, unless I will be staying at the Fisher House (walking distance), I will need a driver/escort to and from the Refractive Surgery Center. I understand that children are not permitted in Refractive Surgery Clinic or at the Refractive Surgery Center.

By signing below, I certify that I have answered the "Special Circumstance" prompts truthfully, and that I agree to, and will comply with, the above "Patient's Agreement."

Applicant's Name

Electronic Signature