

GREAT PLAINS 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
 5. **Eye prescription Older than one year**
 6. Pre-operative evaluation
 7. Color copy of all eye scans (Topography and/or Orbscan)
 - *****ALL COLOR SCANS MUST BE SUBMITTED IN COLOR**
 - If you have access to a color scanner please e-mail them to the address below or if you do not have access to a color scanner, please mail, with a tracking number, to the address below.
7. Submit the complete packet to "GPRMC Refractive Surgery Coordinator" in the following ways:
 1. E-mail: margaret.ross@amedd.army.mil
 2. Fax #: 210-295-2359
 3. Mail to:
2410 Stanley Road Bldg 1029 Suite 121
Fort Sam Houston, TX 78234-6230.

GPRMC 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.

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

Last Name: _____		First Name: _____		MI: _____	Rank/Grade: _____	Date of Application: _____	
SSN: no dashes	Date of Birth: dd/mon/yyyy	Age: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	MOS: _____	ETS Date: dd/mon/yyyy	Likely to Deploy, PCS or attend School in the next 12 months? Approximate Date: (if known)	<input type="checkbox"/> Deploy <input type="checkbox"/> PCS <input type="checkbox"/> 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: <input type="checkbox"/> Active <input type="checkbox"/> Active Guard Reserves <input type="checkbox"/> National Guard <input type="checkbox"/> Reserves <input type="checkbox"/> Other			
Special Duty Status: (Check with your Unit Surgeon before submitting)							
<input type="checkbox"/> Airborne	<input type="checkbox"/> Ranger	<input type="checkbox"/> HALO	<input type="checkbox"/> Aviation (please confer with you flight surgeon about additional paperwork)				
<input type="checkbox"/> Special Operations	<input type="checkbox"/> SCUBA	<input type="checkbox"/> Air Assault	<input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Initials: _____
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: _____ **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 **Projected date (if known):**
Deploy School _____

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: <i>(not the person you bring with you)</i>			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			OCULAR HISTORY		
How many years have you worn glasses?		Ever worn bifocals? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you or have you ever had the following eye problems?	
How old is your current glasses prescription?				Amblyopia / lazy eye <input type="checkbox"/> Yes <input type="checkbox"/> No	
How long have you worn contact lenses?		Last worn? (DD MON YYYY)		Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No	
Contact lens type: <input type="checkbox"/> Soft <input type="checkbox"/> Rigid		Brand worn:		Conjunctivitis, recurrent <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever had difficulty with glasses or contact lens wear? (If YES, please explain further)				Corneal ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Double Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Dry eyes <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No	
				High eye pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Herpes simplex / Zoster <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Keratoconus <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Retinal problems <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Trauma <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Other (specify) _____	
ALLERGIES			MEDICAL HISTORY		
Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please list medication and reaction)</i>			Do you or have you ever had the following?		
			Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Breathing Problems <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No		
			High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Migraine Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Immunosuppression/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No		
			Other Medical Problems (specify) _____		
MEDICATIONS			OCULAR SURGERY		
Are you taking or have you taken any of the following?			Have you ever had surgery or laser treatments on your eyes?		
Date last taken:			<input type="checkbox"/> No <input type="checkbox"/> Yes (specify)		
Accutane (isotretinoin)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Birth control pill	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Cordarone (amiodarone)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Immunosuppressants	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Imitrex (sumatriptan)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
Steroid medication	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			
List other medications that you are currently taking: (or say "none")					
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)	<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART
	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER (Specify)
	<input type="checkbox"/> DIAGNOSTIC STUDIES	
	<input type="checkbox"/> TREATMENT	

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. _____ 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 POSTOPERATIVELY THAT WILL REQUIRE FURTHER TREATMENT BY THE WARFIGHTER LASER SURGERY CENTER.

MINIMUM POSTOPERATIVE APPOINTMENT SCHEDULE

1 WEEK/1,2,3,4,6,AND 12 MONTHS

REFERRING OPTOMETRIST SIGNATURE

DATE

PRINT OR STAMP NAME, RANK

DUTY PHONE

FORT/LOCATION

DUTY FAX