REFRACTIVE SURGERY INFORMATION SHEET

ARMY APPLICATION

Joint Warfighter Refractive

Surgery Center

Website: https://darnall.tricare.mil/Health-Services/Hospital-Care-Surgery/Surgery/Warfighter-Refractive-Eye-Surgery-Program

Contact Information:
Ophthalmology refractive scheduling phone number: 254-286-7851
MHS Genesis Patient Portal: "Ft. Cavazos Ophthalmology"

Requirements for Warfighter candidates:

- Active Duty for at least 6 months
- Wearing glasses for at least a year
- 21 years or older
- No planned deployments for 6 months
- No adverse personnel actions pending
- Commander's permission
- 6 months left in the military after surgery

You must submit the following to our refractive surgery inbox:

1. **LASIK/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 surgical evaluation and 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.

** 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 14 days

Toric or Rigid 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

Last updated Sep2024

CRDAMC 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 14 days *and out of rigid contact lenses a minimum of 30 days per decade worn 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. *Incomplete forms will not be accepted and will not be submitted until all information is completed. Please allow three weeks for processing.*
6. *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 Cavazos, 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 Do not use Indefinite	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:** _____ (**Do not** use "**indefinite**") 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 12 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 6 months remaining on Active Duty
   b. Soldier has no adverse personnel actions pending
   c. Soldier will remain CONUS for at least 60-90 days after surgery

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.

Please highlight or circle one of the following according to which category applies to this individual:

a. Priority 1 – Combat Arms MOS
b. Priority 2 – Attached to Combat Arms unit/ Deployable units
c. Priority 3 – Space Available

. 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.

. This authorization is good for 180 days from the date it is signed by the Commander. If surgery is scheduled more than 180 days from the date it is signed, re-authorization will need to be accomplished.

_____
Commanders Signature

_____
Commanders Name and Rank

_____ _____
Date Phone

_____
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
Given Birth or Nursing in last 6 months	☐Yes	☐ No

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)*