JBER REFRACTIVE SURGERY CENTER INFORMATIONAL SHEET

Last, First, MI, Suffix (Jr., III):_____ **Rank:** _____

SSN (FMP/xxx-xx-xxxx): _____**Age/DOB (annotate both):**_____ **Sex:** _____

Service: ☐ **USAF** ☐ **USA** ☐ **USN/USMC** ☐ **USCG** ☐ **OTHER** _____ **Status:** ☐ **Active Duty** ☐ **Guard** ☐ **Reserve**

Occupation/AFSC/MOS (annotate both):_____ **Flying Status:** YES ☐ NO ☐ **ASC:** _____

Date of Separation/Retirement: _____ **A date is absolutely required.**

CURRENTLY ANTICIPATE OR UNDERGOING MEB: _____

Contact Info:

Address:_____ Unit:_____

Phone(H):_____ Base:_____

Phone(C):_____ Phone(W):_____

Mililtary Email: _____ Personal Email: _____

Commander's Name:_____

Commander's Email: _____

Medical Information: (please annotate completely. If nothing to annotate, please write "nothing")

Drug Allergies: _____

Current Medications: _____

Medical History: _____

Surgical History: _____

Do you now or have you ever had any of the following eye conditions?

	YES	NO		YES	NO		YES	NO
Glaucoma	☐	☐	Keratoconus	☐	☐	Ocular allergies	☐	☐
Dry eyes	☐	☐	Cataract	☐	☐	Strabismus/lazy eye	☐	☐
Eye surgery	☐	☐	Eye injury	☐	☐	Corneal infection/scars	☐	☐
Retinal problems	☐	☐	Ocular Rosacea	☐	☐	Ocular Herpes infection	☐	☐

Do you have any of these medical conditions?

	YES	NO		YES	NO		YES	NO
Diabetes	☐	☐	Psoriasis	☐	☐	Immunosuppression	☐	☐
Migraines	☐	☐	Pacemaker	☐	☐	Tuberculosis or positive PPD	☐	☐
Acne rosacea	☐	☐	Thyroid Disease	☐	☐			

Do you have an autoimmune disease or have you been evaluated by a specialist for possible autoimmune disease? YES ☐ NO ☐

Examples: Rheumatoid arthritis, Lupus, Multiple Sclerosis, Sarcoid, Sjogren's, Irritable Bowel Disease, HLA B27, psoriasis, vitilligo

Have you ever taken any of the following? YES ☐ NO ☐ If yes, mark box and indicate LAST DATE used in blanks.

☐Steroids _____ ☐Small pox vaccine _____ ☐Accutane (Isotretinoin)_____

☐TB meds (INH)_____ ☐Immitex (sumatriptan) _____ ☐Cordarone (Amiodarone)_____

Have you ever worn contact lenses? YES ☐ NO ☐ If yes, which type: ☐Soft ☐Hard ☐Unsure

How many years? _____ How many hours per day? _____ What date did you last wear? _____

****Soft contact lenses *must not be worn* 30 days prior to the preop exam or surgical date. Rigid Gas Permeable contacts *must not be worn* 90 days prior to the preop exam/surgical date. Initial here that you have read and understand this statement _____****

Females Only: Are you currently pregnant or planning to become pregnant in the next 6 months? YES ☐ NO ☐

Are you nursing or have you been nursing/pregnant in the last 6 months? ☐ ☐

List your hobbies or activities having special visual requirements (Ex: flying, swimming, golf, shooting, sewing)

_____

Describe your expectations from refractive surgery: (Ex: to see the clock in the morning, while swimming)

_____

I, _____, AFFIRM THAT THE INFORMATION CONTAINED HEREIN IS TRUE, CORRECT, AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. Signature: _____ Date: _____

(This form is subject to the Privacy Act of 1974 – DD Form 2005)

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:	
DOD ID:	PROJECTED ROTATION DATE: *(YYYYMMDD)*
HOME EMAIL:	CURRENT END OF ACTIVE DUTY COMMITMENT: *(YYYYMMDD)*
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.

JBER Warfighter Refractive Surgery Center

Post Refractive Surgery Physical Profile Restrictions:

180 days:

- Sunglasses (UV protective eyewear) must be worn while outdoors regardless of brightness or perceived needs. (30 days indoors for comfort/physical safety)

60 days:

- Non-Deployable / No airborne Ops
- No PCS (unless approved by gaining base optometrist)
- Cannot carry or fire individual assigned weapons, no evading direct / indirect fire (60 days PRK/30 days LASIK)
- No riding in tactical military vehicle more than 12 hours per day (60 days PRK/30 days LASIK)
- No wearing body armor for more than 12 hours per day, No wearing protective mask / MOPP 4 for more than 2 continuous hours per day (60 days PRK/30 days LASIK)
- No moving greater than 40lbs while wearing usual protective gear (helmet, weapon, body armor, and LBE)
- No living/working in austere environment (60 days PRK/30 days LASIK)
- Flyers: DNIF (60 days PRK/30 days LASIK)

30 days:

- No swimming/saunas/hot tubs/water sports
- No driving government vehicles or heavy machinery (or until cleared by provider)
- No contact sports, group/unit PT (Individual PT at own pace/distance
    - (Individual may participate in fitness program requirements that do not involve contact sports)
- No gas chamber, gas masks or chemical warfare training
- No exposure to chemicals, solvents, fumes or dust.

14 days:

- No APFT

7 days:

- No Exercise
- No driving personal vehicle

Applicant:

I understand that after my refractive surgery procedure I will be placed on a physical profile/light duty restriction. I understand that once the procedure is completed, the profile will not be changed. I understand that I must plan for any training, TDY, PCS, or any other activities that may be affected due to my physical profile.

Signature:_____ Date:_____

Supervisor:

Signature:_____ Date:_____

Printed Name:_____ Email:_____

USAF WARFIGHTER CORNEAL REFRACTIVE SURGERY APPLICATION

Application IAW USAF-CRS Warfighter Program Management (READ ALL INSTRUCTIONS PRIOR TO COMPLETING FORM)

This form and other USAF-RS Tools are available on AF Knowledge Exchange (DotMil) USAF-CRS website or Public Access Public Access

Application Date:

APPLICANT INFORMATION

Last Name	First Name	Middle Initial
SSN (last 4)	DOB	Age

Grade/ Rank	Primary AFSC	Sex	☐ Male ☐ Female

Duty Status ☐ AD ☐ Other — If not AD, please include a copy of current orders

MAJCOM –

Total # months of remaining AD retainability (eligible for elective surgery benefits)

NOTE: AF personnel MUST HAVE 6 months retainability AFTER the Date of Surgery.

Unit/Squadron & Office Symbol	Phone (DSN)

Street

Base / State Zip + 4

Duty E-mail

Planned RS treatment Location –

Preferred RS Treatment	☐ Advanced Surface Ablation (ASA) (PRK, Epi-LASIK, LASEK, WFG-PRK)	☐ Intra-Stromal Ablation (ISA) (LASIK, FS-LASIK, WFG-LASIK)	☐ Any Approved USAF RS Procedure

Applicant's Signature

This application form is for use by **USAF Warfighter personnel** seeking CRS Treatment at a DOD (military) facility.

Aviation / Aviation Related Special Duty (AASD) personnel or AF members seeking treatment at a civilian RS center, please refer to the USAF-CRS website for specific application requirements and forms.

FOR USAF-CRS WARFIGHTER PROGRAM MANAGER (WPM) ENDORSEMENT ONLY

Disposition Date	Permission to Proceed? ☐ Yes ☐ No

Reviewing Officer's Name/Rank

Reviewing Officer's Signature

MANDATORY QUESTIONS (APPLICANT MUST INITIAL)

Initials	I am responsible for reading and complying with the policy and guidelines of USAF-CRS Program available at: https://kx.afms.mil/kj/kx1/AFRefractiveSurgery/Pages/home.aspx or (Public Access) http://www.wpafb.af.mil/Welcome/Fact-Sheets/Display/Article/841456/usafsam-usaf-corneal-refractive-surgery-program/.
Initials	I understand I am **NOT** authorized to undergo refractive surgery until I have received "Permission to Proceed" authorization from the USAF-CRS Warfighter Program Manager. If granted "Permission to Proceed" authorization, the treatment is not guaranteed. Final decision to treat will be made by the treating refractive surgeon.
Initials	I understand my Commander's Authorization **expires 6 months** from the date of their signature. If I am unable to compete treatment within this authorized period, I will obtain a new Commander's Authorization which must be submitted to the Warfighter Program Manager. A valid authorization is mandatory for USAF-CRS treatment.
Initials	I must inform my primary care manager and eye care provider upon surgery treatment, any required follow-up care, and in the event of any complications. If follow-up examinations as required by policy is not accomplished, I may be restricted from duty until in compliance.
Initials	I understand the final decision whether to perform CRS and/or recommended technique will be determined by my treating surgeon. At any time, I may be disqualified for corneal refractive surgery or I may elect not to undergo treatment.
Initials	If I am disqualified as a CRS candidate, I am not eligible for reimbursement of expenses incurred for travel to/from the DoD RS center, including, but not limited to travel, meals, and lodging. (This does not apply if I am unit-funded.)
Initials	I understand I may require or continue to require reading and/or distance prescription correction for best vision after surgery. Furthermore, I understand there is a chance I cannot be fit with contact lenses for vision correction, if desired, after CRS.
Initials	I understand CRS is a non-reversible, alteration of my vision and, even with optimal outcome, my vision may change over time.
Initials	I understand my vision will require time to fully recover following CRS Surgery and there is a risk of not meeting relevant vision standards after CRS. Therefore, I may be disqualified from certain careers, duties, or even continued military service.

Submission of application package: If choosing an AF CRS Center, contact and submit completed package to desired RS Center.If choosing a non-AF RS center, submit completed package for review to: the WPM - Joint Service Refractive Surgery Center, Lackland AFB. mail to: WHMC-CRS@us.af.mil

AF RS CENTER	DSN - Voice	COM - Prefix	FAX	Email Address
Lackland AFB	554-2237/3495/4420	210-292-xxxx	xxx-2313/2813	usaf.jbsa.59-mdw.mbx.warfighter-refractive-surgery-center@mail.mil
Air Force Academy	333-0525	719-333-xxxx	xxx-9774	usaf.usafa.10-mdg.mbx.10-mdg-sgose@mail.mil
Andrews AFB	857-1730	240-857-xxxx	xxx-8226	usaf.jbanafw.779-mdg.mbx.wfec-andrews@mail.mil
Keesler AFB	591-0567	228-376-xxxx	xxx-0155	usaf.keesler.81-mdg.mbx.refractive-surgery-org@mail.mil
Travis AFB	799-3146	707-423-xxxx	xxx-3529	usaf.travis.60-mdg.mbx.dgmclasercenter@mail.mil
Wright-Patterson AFB	986-0970 / 1447	937-656-xxxx	xxx-0973	usaf.wright-patt.88.mdg.mbx.laser-center@mail.mil
JB Elmendorf-Richardson	317-580-2020	907-580-xxxx	xxx-1152	usaf.jber.673-mdg.mbx.673-refractive-surgery@mail.mil

USAF Corneal Refractive Surgery (USAF-CRS) Program

Managed Care Agreement

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

Patient Name Rank

_____ _____ _____

Military Installation Phone E-mail

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

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 myfirst follow-up appointment as soon as I am notified of my surgerydate.

_____ I understand that I must complywith and accomplish all required referral and follow-up evaluations as required by USAF policy. Non-compliance mayresult 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 can not 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 mymilitarymedical records.

_____ _____

Patient Signature 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 responsibilityfor 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 expiration date provided below.

_____ _____

Referring Optometrist Stamp/Signature Co-management expiration Date
(not to exceed one year from exam date)

_____ _____ _____ _____

Military Installation Phone Fax E-mail

JBER JOINT WARFIGHTER REFRACTIVE SURGERY CENTER
PATIENT INFORMATION PAGE 2of2

Preferred language: ☐ English ☐ Other: _____

What is your preferred method of learning? ☐ Written ☐ Visual ☐ Other:

(if other specify): _____

Do you have a learning disablity, language barrier/hearing/vision deficit? ☐ No ☐ Yes

(if yes specify): _____

Do you have an advance directive completed? ☐ Yes ☐ No

Is a copy of the advance directive in your record? ☐ Yes ☐ No

Do you have any cultural or religious beliefs that may affect your care? ☐ No ☐ Yes

(if yes specify): _____

I understand that by committing to the refractive surgery program I will adhere to the post-op mandatory 1week, 1, 3, 6 & 12 month follow-up visits, even if I PCS after treatment is provided. These are WRESCu directed and not a choice. Failure to comply with follow up appointments or persistent no-shows will result in notification to my leadership.

Signature _____