MCXD-DOS-OPH 08 November 2018

MEMORANDUM FOR RECORD

SUBJECT: Refractive Surgery Not Performed At Duty Station

Refractive surgery requires an intensive pre-operative evaluation and multiple post-operative examinations to ensure a successful surgery. All pre-operative evaluations will be conducted at the Warfighter Refractive Eye Surgery Clinic (WRESC) at Fort Campbell. Post-operative examinations may be completed at the Service Member's home duty station only if an agreement exists between the WRESC and an Optometrist or Ophthalmologist at the Service Member's home duty station. This must be a pre-existing arrangement to see all post-operative refractive patients and is not arranged on a case by case basis. If this relationship does not exist for a particular duty station, then all follow-up examinations must be performed at the WRESC on Fort Campbell. The Service Member should understand the following:

1) LASIK will not be offered to Service Members having refractive surgery performed outside their home duty station unless there is a pre-existing arrangement to follow these patients by an Optometrist or Ophthalmologist at their home duty station.
2) Service Members will be required to return to Fort Campbell for multiple post-operative examinations. At a minimum, this includes 4-5 day, 1-month and 3-month visits for all PRK patients.
3) If a complication occurs, the Service Member may be required to return for multiple visits over a short span of time.
4) If the Service Member is traveling PTDY the expense of all future visits, whether related to a complication or not, will also be at his/her own expense.
5) If the Service Member is using personal leave, the expense of all future visits, whether related to a complication or not, will also be at his/her own expense. He/she may also be required to take additional personal leave for all additional required visits.

The POC for this memorandum is at usarmy.campbell.medcom-bach.list.wresp-users@mail.mil or (270) 956-0775.

Chief, Warfighter Refractive Eye Surgery Center

Blanchfield Army Community Hospital
Warfighter Refractive Eye Surgery Center
Phone (270) 956-0775 Fax (270) 956-0770
E-mail: usarmy.campbell.medcom-bach.list.wresp-users@mail.mil

Procedures for screening and selection for the Refractive Surgery Program:

Qualifications:

ONLY Active Duty Service Members 18 years of age and have 6 month service obligation remaining from the day of surgery may apply*

1. The Service Member (SM) will have the Commander's (CDR) Endorsement (page 3), Refractive Surgery Checklist (pages 4-5), Managed Care Agreement (page 6) and Aviation Commander's Authorization (page 7) *if applicable*, completed before any other steps can be taken by the Warfighter Refractive Eye Surgery Center (WRESC). The exact method and order for completing each form may vary from unit to unit – details for this are left up to each command. If all forms are a "GO", then the SM proceeds to the next step.

2. Once the entire packet is completed, fax or email the packet and all supporting documents as listed below. The SM will then contact the Warfighter Refractive Eye Surgery Center at (270) 956-0775 to ensure receipt.

-- The complete packet (pages 1-7) **No retyped packets will be accepted.**
-- Commander's Endorsement **MUST** be signed by current Company (at least O3) and Battalion (at least O5) level or higher commander and be less than 90 days old. If signed by acting Company/Battalion CDR, bring a copy of the assumption of command orders.
-- ID Card (CAC)
-- Proof of ETS or separation date **(Enlisted and Officer—ERB/ORB, RE-UP, etc.)**
****AGR Service Members MUST provide a copy of AGR orders.****
-- Bring your current glasses or be able to provide an eyeglass prescription older than one year to your 1st Preoperative appointment.
--CONTACT LENSES NEED TO BE OUT FOR AT LEAST 14 DAYS PRIOR TO THE FIRST APPT. DO NOT WEAR ANY CONTACT LENSES UNTIL AFTER YOUR SURGERY ELIGIBILITY HAS BEEN DETERMINED

3. Once all of the above documentation has been presented to and verified by the Warfighter Refractive Eye Surgery Center staff at Blanchfield Army Community Hospital, then the SM will be booked for two preoperative appointments.

4. Refer all questions to the Warfighter Refractive Eye Surgery Center at 270-956-0775.

(Office Symbol)_____ (Date)_____

MEMORANDUM TO OIC, Warfighter Refractive Surgery Clinic, Blanchfield ACH

SUBJECT: Commander's Endorsement of Refractive Eye Surgery

1. I hereby give my endorsement/permission for the below listed active duty Service Member (SM) to be evaluated for enrollment in the refractive eye surgery program.

NAME: _____ DOB:_____
Last First MI
***DoD ID Number: _____ ETS DATE: _____**
RANK: _____ SERVICE: _____
DUTY TITLE: _____ MOS: _____
ASSIGNED UNIT: _____
CONTACT ADDRESS: _____
CONTACT PHONE: (DAY) _____ (EVENING) _____
E-MAIL ADDRESS: _____.mil@mail.mil_____

***Your DoD ID Number is located on the back of your Military ID (CAC) Card.**

F-I realize that after the surgery, the SM will have the following profile for a minimum of **30 days**: NO FIELD DUTY, AIRBORNE OPS, SWIMMING OR SCUBA, TACTICAL NIGHT OPS, GAS MASK, CAMMO FACE PAINT, and DRIVING MILITARY VEHICLES. SUN-GLASSES MAY BE WORN AS NEEDED INDOORS AND OUTDOORS FOR **90 DAYS**. NO PHYSICAL TRAINING FOR 2 WEEKS (14 DAYS).

G-I further realize that the Soldier MUST remain CONUS for at least 90 days following refractive surgery.

H-The SM will be on unit convalescent leave for up to 6 (six) days following surgery and **must keep all follow-up appointments** with the Warfighter Refractive Eye Surgery Clinic to avoid potential complications.

I-The SM must have 6 (six) months remaining on station and have a minimum of 6 months active duty service commitment remaining from surgery date. ETS date must be verified by official document.

I authorize the SM treatment in accordance with all information provided above. Additionally, I am aware that the Commander's signatures are only valid for 90 days.

_____	_____
Company Commander's (O3) Signature/ Date	**Battalion Commander's (O5) Signature/Date**
_____	_____
Company Commander's Name and Rank	**Battalion Commander's Name and Rank**
_____	_____
Unit	**Unit**
_____	_____
Company Commander's Telephone and E-mail	**Battalion Commander's Telephone and E-mail**

Fill In Every Blank, Do Not Alter this form or Retype It

Refractive Surgery Checklist (RSC)

[ ] Flight Status [ ] Non-flight Status

1. Unit Approval and Verification *(check answers)* [ ] GO[ ] NO GO

Service Member (SM) is at least 18 years old

[ ] Yes [ ] No

SM has at least 7 months active duty service commitment remaining
(Program requires 6 months from day of surgery; 1 additional month allows for scheduling)

[ ] Yes [ ] No

Is the SM projected to PCS within 6 (six) months? *If Yes, when and where*_____

[ ] Yes [ ] No

Does the SM have any pending personnel actions/UCMJ/Flagged/Bar to Reenlist?

[ ] Yes [ ] No

Do you have projected deployment dates/time frame

[ ] Yes [ ] No *If Yes, give dates/time frame* _____

Do you have projected JRTC/NTC dates/time frame

[ ] Yes [ ] No *If Yes, give dates/time frame* _____

Do you have projected school dates/time frame

[ ] Yes [ ] No *If Yes, give dates/time frame* _____

_____

First Sergeant (E7/E8) Signature *Date*

_____

Rank *Last Name* *First Name* *MI* *Telephone Number*

2. Medical History *(Any item checked is a "NO GO".)* [ ] GO [ ] NO GO

[ ] uncontrolled vascular disease
[ ] autoimmune disease
[ ] immunosuppressed/compromised
[ ] pregnant, breastfeeding, less than 6 months postpartum or less than 6 months since last breastfeeding
[ ] history of keloid formation
[ ] diabetes
[ ] use of isotretinoin (Accutane) or amiodorone (Cordarone)

_____

date, printed name, signature & phone number of Medical Reviewer (E6 or above at Battalion Aid Station or MTF)

_____

Last Name, First, MI *(of applicant)* **Rank**

_____

Date of Birth **DoD ID Number**

Refractive Surgery Checklist (RSC), continued

3. Ocular History *(Any item checked is a "NO GO".)* [ ] GO [ ] NO GO
[ ] keratoconus
[ ] herpetic keratis
[ ] progressive myopia
[ ] corneal disease
[ ] glaucoma
[ ] cataract
[ ] amblyopia

4. Refraction *(less than 1 year old)* date _____ [ ] GO [ ] NO GO
(subjective refraction, subject, manifest refraction, manifest, refraction, or MR)
[retinoscopy or auto-refraction and "refractions" from physicals are not acceptable]

OD (sphere) _____ (cylinder) _____ (axis) _____ (unaided VA) _____

OS (sphere) _____ (cylinder) _____ (axis) _____ (unaided VA) _____

Wears corrective lenses full time [ ] Yes [ ] No Bifocal/Near Add_____

Wears contact lenses [ ] Yes [ ] No (if yes are they _____soft or _____rigid)

Myopia
Sphere is between –1.00 and –10.00 [ ] Yes [ ] No
Cylinder is –4.00 or less [ ] Yes [ ] No

Hyperopia
Sphere is between "plano" (zero) and +3.00 [ ] Yes [ ] No
Cylinder is –6.00 or less [ ] Yes [ ] No

_____
Printed Name, Signature, of Optometrist Date

_____
Last Name, First, MI *(of applicant)* **Rank**

_____
Date of Birth **DoD ID Number**

Warfighter Refractive Eye Surgery Program
Managed Care Agreement

(FOR POST-OPERATIVE CARE AT A FACILITY OTHER THAN Blanchfield Army Community Hospital)

Patient Name (Print)	**Rank**	**DoD ID Number**

Military Installation	**Phone**	**E-mail (One you use frequently)**

In the next 6 months are you: _____ _____ _____ _____

Deploying (Yes/No) | If Yes, when? (mmyy) | PSC'ing (Yes/No) | If Yes when? (mmyy)

Patient Agreement (initial each statement)

_____ I request to be returned to my Optometry Clinic at _____ for post-operative care following refractive surgery at Blanchfield Army Community Hospital. The Refractive Surgery Center staff will be available for additional consultation as needed.

_____ I will contact this Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my surgery date.

_____ I understand that post-operative follow-up appointments are required at 4/5-days, 1-, 3- and 6-months. If I am deploying before the 6-month exam is due I will complete the 4/5-day, 1- and 3-month exams and then return to the Optometry Clinic for a post-operative exam at the completion of my deployment. I understand that the **4/5-day and 1-month** follow-up appointments **MUST** be completed at Fort Campbell.

_____ _____

Patient Signature | Date

Co-Managing Provider's Agreement (initial each statement)

_____ I agree that I will manage this patient and accept responsibility for his/her post-operative care. Post-operative appointments will be scheduled at 3- and 6-months. If the soldier is deploying before the 6-month exam is due then they will complete the 3-month exam and then return for a post-operative exam at the completion of their deployment.

I will email or fax the results of each follow-up exam to the Center for Refractive Surgery at BACH.

_____ _____ _____ _____

Optometrist Stamp/Signature | Optometrist's Name (Print) | Rank | Date

_____ _____ _____ _____

Military Installation | Phone | Fax | Email

Appendix 1: Aviation Commander's Authorization

Memorandum to: Unit

Flight Surgeon CC:

Ophthalmology, Refractive

Surgeon

Subject: Authorization for Aircrew members to receive refractive surgery under the Aeromedical Policy Letter for Refractive Surgery and the Corneal Refractive Surgery Surveillance Program.

1. _____, DoD ID Number _____
is authorized to receive refractive surgery per the guidance outlined in the Aeromedical Policy Letter: Corneal Refractive Surgery.
2. This authorization is based on the following understandings:

a. This authorization does not constitute a medical waiver; it only authorizes the individual to have refractive surgery. The individual will be DNIF for at least 6 weeks, up to a maximum 12 weeks. The medical waiver request will be submitted to USAAMA upon receipt of information from the flight surgeon as to the successful outcome of the individual's surgical procedure. USAAMA will determine if the individual meets the medical waiver requirements when the applicant's eyes and vision meet and retain FDME standards and all requirements for waiver have been met.

b. In approximately 2-3 of every 1,000 refractive surgery procedures (0.2 to 0.3%), the individual will not recover 20/20 best-corrected vision after surgery. Individuals who fall in this category will be evaluated by USAAMA to determine whether a waiver to continue on flight status may be issued. Although slight, there is a possibility the individual may lose his/her flight status in the event of significant visual loss that cannot be resolved.

c. Questions about the updated policy may be directed to USAAMA at 334-255-7430; questions about refractive surgery to the local eye care provider.

d. A copy of this correspondence will be kept on file in the local flight surgeon's office.

3. POC is the undersigned at _____.

Commander's Signature Block