

TRIPLER ARMY MEDICAL CENTER REFRACTIVE SURGERY CENTER (RSC)

OAHU PATIENTS

NAME/RANK: _____

HOME NUMBER: _____

CELL PHONE: _____

PLEASE ENSURE THE FOLLOWING IS COMPLETE PRIOR TO ATTENDING THE REFRACTIVE SURGERY INFORMATION BRIEFING

- PRINT THIS REFRACTIVE SURGERY PACKET
- READ THE ENTIRE PACKET, INCLUDING THE CONSENT FORM
- COMPLETE THE YELLOW HIGHLIGHTED AREAS ON ALL PAGES
- PRINT THE COMMAND AUTHORIZATION FORM FOR YOUR APPROPRIATE SERVICE (Navy/USMC/USCG – USAF – USA)
- ROUTE THE COMMAND AUTHORIZATION FORM THROUGH YOUR CHAIN OF COMMAND – WE WILL NEED THE ORIGINAL SIGNED FORM NO LATER THAN THE DAY OF YOUR COMPREHENSIVE REFRACTIVE EVALUATION (CRE) AT OUR CENTER
- OBTAIN A COPY OF A GLASSES PRESCRIPTION, OR AN EYE EXAM WITH A DOCUMENTED PRESCRIPTION, THAT IS AT LEAST ONE YEAR OLD AND BRING THIS TO THE RSC BRIEFING

* IF YOU HAVE ANY QUESTIONS PLEASE ASK THEM DURING THE BRIEFING OR DURING YOUR PRE-OPERATIVE EVALUATION

.....

I would like to pick up my medications for surgery at the following pharmacy: (check one)

Tripler Hospital Main Pharmacy

Schofield Barracks Pharmacy

Makalapa/Pearl Harbor Pharmacy

USMC Base Kaneohe Bay Pharmacy

TRIPLER ARMY MEDICAL CENTER - REFRACTIVE SURGERY CENTER

Patient Education Checklist

I, _____ (rank/Name/Last 4), am requesting an evaluation for refractive surgery at the Tripler Army Medical Center Refractive Surgery Center in Honolulu, Hawaii. By signing below I am verifying that I have read and understand the following information.

***Initial by each statement if you understand and agree**

I acknowledge that I have reviewed the Refractive Surgery Briefing PowerPoint. I understand that I am to list any questions and discuss them with the doctors at the Tripler RSC prior to surgery.

I understand that certain medical or ocular conditions may exist that may disqualify me from having refractive surgery.

I understand that I should inform my surgeon if I am currently taking any acetaminophen (Tylenol)-containing medications, sedatives (sleep aids) or narcotics, as these may interact with my post-op medications.

I understand that I must not wear contact lenses, as discussed in the RSC briefing PowerPoint, prior to my evaluation at Tripler RSC (Soft lenses-2 wks; Hard/Toric-4 wks)

I understand that I must adhere to the guidelines stated in the RSC PowerPoint briefing, with respect to TDY/Leave/Deployment restrictions after surgery

I understand that, due to equipment problems, my surgery date may have to be postponed for an indefinite period of time.

I understand that I must bring the following items with me when I have my Comprehensive refractive evaluation at Tripler RSC: military ID. Original signed Command Authorization form, current glasses and any available spectacle/contact lens prescriptions that are at least one year old.

(Females only) I understand that if I am currently pregnant, or may be pregnant, or I have nursed or been pregnant within the past six months I cannot have refractive surgery at this time.

I understand that I will not be able to have surgery if I miss any pre-operative exams

I understand that an escort/driver is required to take me home after my surgery, and to bring me back to the RSC for my first post-operative exam.

I have verified with my command that I am eligible to receive refractive surgery in my current/prospective occupational code (e.g. Flight Status/Special Forces/Diver/etc.)

I have read and understand the Refractive Surgery policy letter (found on Tripler Refractive Surgery website) for my branch of service. I understand that I cannot PCS for up to three months after PRK/ICL/Refractive Lens Exchange, or 1 month after LASIK.

Service member's printed name

Signature

Date

REPORT TITLE INTERDISCIPLINARY PATIENT /FAMILY TEACHING FLOWSHEET	OTSG APPROVED (Date) (YYYYMMDD)
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If change in education assessment, then a new Patient Encounter Flowsheet will be Initiated.

Assessment of Abilities and Barriers to Learning: may completed by patient/family member

If completed in another document, check box below:

- MEDCOM FORM _____
 CIS
 SF 600
 ALTHA

To be answered by patient/family member:

1. How do you best learn new information? Reading Videos Computer Demonstration
 Other _____
2. Do you communicate in English Other _____
3. Do you have any Religious or Cultural beliefs that would be a barrier to learning? No Yes (If yes, please explain)
 Comment _____
4. Do you have any Physical Barriers to your learning: None Vision Hearing,
 Other _____
5. Do you have any Emotional Barriers to learning : None Fear Anxiety Depression
 Comment _____

Staff Assessment:

7. **Readiness To Learn:** Exhibits readiness to learn? Yes No Comment _____
8. **Cognitive:** Exhibits ability to grasp concepts & responds to questions? Good Limited Other
 Comment _____

Learning Objectives: Laser Clinic Encounter (List Patient/Family Teachings below and on back)	Date & Signature When Met	Pt: V &/or D
1. Attended Laser Briefing and verbalize the understanding and expectations of Laser Refractive Surgery.		
2. Verbalize understanding the proper usage of prescribed medication.		
3. Verbalize the understanding of the healing process for specific refractive procedure.		
4. Understand pre/post-operative instructions.		

Pt response: V = Pt Verbalized understanding, D = Pt Demonstrated understanding:
(write N/A in date & initial column, if objective is not applicable)

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name last, first, middle; grade; date; hospital or medical facility)

- HISTORY/PHYSICAL FLOW CHART
 OTHER EXAMINATION OR EVALUATION OTHER (Specify)
 DIAGNOSTIC STUDIES
 TREATMENT

PATIENT QUESTIONNAIRE

OFFICE USE ONLY

Ticket #

Appt Date:

@

Please fill out form completely

Date: _____ SSN: _____

Name: _____ Rank: _____
(Last) (First) (MI)

Age: ____ Date of birth: DD / Month / YY Gender: Male Female Branch: _____

Job Description: _____ Unit: _____

Email address: 1) Personal - _____ (required)

2) Military - _____ (required)

Home Address: _____

Phone number: Home: _____ Work: _____

Cell: _____ Pager: _____

In your own words, please list your expectations for your vision after surgery:

Example: *To be able to wake up and see the clock without glasses.*

- 1.
- 2.

Are you currently, or planning to apply for FLIGHT STATUS or SPECIAL OPS ? YES / NO

Are you deploying to Afghanistan or Iraq within the next TWELVE months? YES / NO

If so, estimated date deploying? _____

Are you Combat Arms? YES / NO

Are you Combat Support? YES / NO

Do you wear contact lenses? YES / NO

1) Type: Soft Soft Toric Rigid Gas Permeable/Hard Unsure

2) If so, for how many years _____

3) ****Date last worn:** _____

How long have you worn glasses? _____ years, since age _____

How old are the glasses you are wearing? _____

How long has your eyeglass prescription been unchanged? _____

Name: _____ Date of birth: _____ Last 4: _____
(Last) (First) (MI) (Example: 01 Jan 80)

Medical/Eye History:

A) Please list any food, dye or medication allergies:

B) Please list all prescribed/over-the-counter medications you take regularly:

C) Do you have any **family history** of retinal detachment, keratoconus, pellucid marginal degeneration, glaucoma or other eye disease? YES / NO

D) Please circle a number for each of the following questions using the scale below:

(Scale: 0 - None, 1 - Minimal, 2 - Mild, 3 - Moderate, 4 - Severe, 5 - Extreme)

Dry eye symptoms?	0	-	1	-	2	-	3	-	4	-	5
Glare or halos?	0	-	1	-	2	-	3	-	4	-	5
Chronic eye pain?	0	-	1	-	2	-	3	-	4	-	5
Claustrophobia?	0	-	1	-	2	-	3	-	4	-	5
Poor vision, even with contacts or glasses	0	-	1	-	2	-	3	-	4	-	5

E) Do you now, or have you ever been told that you have:

(if YES, please explain in the space provided in section G, next page)

Diabetes	YES / NO
High Blood Pressure/Heart Disease	YES / NO
HIV	YES / NO
Rheumatoid Arthritis	YES / NO
Lupus	YES / NO
Autoimmune Disease	YES / NO
Poor wound healing	YES / NO
Depression	YES / NO

F) ****Females:** Are you pregnant or have you been pregnant in the last 6 months, nursing, or nursed in the past 6 months? Yes / No

Name: _____ **Date of birth:** _____ **Last 4:** _____
(Last) (First) (MI) (Example: 01 Jan 80)

G) Please circle YES or NO for the following questions:

Have you ever had, or has anyone ever told that you have the following? (If you are unsure, skip it.)

- | | | |
|--|-----|----|
| 1. Recurrent iritis or uveitis? | YES | NO |
| 2. A herpes infection in your eyes? | YES | NO |
| 3. A corneal scar? | YES | NO |
| 4. Glaucoma? | YES | NO |
| 5. Steroid responder? | YES | NO |
| 6. Cataracts? | YES | NO |
| 7. Corrected vision less than 20/20 with glasses/contacts? | YES | NO |
| 8. A “lazy eye” or amblyopia? | YES | NO |
| 9. Keratoconus? | YES | NO |
| 10. Retinal Detachment | YES | NO |
| 11. Significant eye trauma | YES | NO |
| 12. Any surgeries in the past 5 years? | YES | NO |
| 13. Prior eye surgery, including PRK or LASIK? | YES | NO |
| 14. Been told that you are not a good PRK/LASIK candidate? | YES | NO |

If YES to any of the above, explain here.

Patient Name: _____

Signature: _____

Date: _____

INFORMED CONSENT FOR CORNEAL REFRACTIVE SURGERY

LASER IN-SITU KERATOMILEUSIS (LASIK) and PHOTOREFRACTIVE KERATECTOMY (PRK)

INTRODUCTION

This information is being provided to you so that you can make an informed decision about LASIK or PRK as a surgical option to reduce or eliminate your need for glasses and/or contact lenses. Both LASIK and PRK are irreversible surgical procedures which use the excimer laser to treat nearsightedness (myopia), farsightedness (hyperopia) and astigmatism by reshaping the cornea. PRK surgery is performed by applying the laser to the surface of the cornea after removal of the superficial skin cell layer (epithelium). LASIK surgery is performed by creating a partial-thickness hinged corneal flap (using a femtosecond laser or mechanical microkeratome), lifting the flap and applying the laser to the exposed corneal tissue. The flap is then returned to its original position.

LASIK and PRK are purely elective procedures. You are not required to have either procedure, and the decision to have either procedure will be made by you after appropriate education and research. You can continue wearing contact lenses or glasses and likely have adequate visual acuity. This procedure, like all surgery, has associated risks, many of which are listed below. You should also understand that there may be other risks not known to your doctor, which may only become evident at some future time. Complications and side effects may occur, despite having the best care possible, which could cause permanent loss of vision

ALTERNATIVES TO LASIK and PRK

If you decide not to have LASIK and PRK, other methods of correcting your vision include, among others, eyeglasses, contact lenses and other refractive surgical procedures.

PATIENT CONSENT

In giving my permission for LASIK or PRK, I understand the following: The long-term risks and effects of LASIK and PRK are unknown. I have received no guarantee as to the success of my particular case. I understand that the following risks are associated with the procedures:

VISION THREATENING COMPLICATIONS (risk < 1%)

1. I understand that the microkeratome/femtosecond laser or the excimer laser could malfunction, requiring the procedure to be stopped before completion. Depending on the type of malfunction, this may or may not be accompanied by visual loss.
2. I understand that, during flap creation for LASIK, instead of making a flap, an entire portion of the central cornea could be cut off, and very rarely could be lost. If preserved, I understand that my doctor would put this tissue back on the eye after the laser treatment. It is also possible that the flap incision could result in an incomplete flap, irregular flap, decentered flap, or a flap that is too thin. If this happens, it is likely that the laser part of the procedure will have to be postponed until the cornea has a chance to heal sufficiently to try to create the flap again, usually 4-6 months later.
3. I understand that, during flap creation for LASIK, a superficial corneal abrasion (epithelial defect) could result in approximately 2-3% of the patients. This may require a bandage soft contact lens for 1-3 days until the defect has healed. I understand that I would require more intensive topical (and possibly oral) steroid medication treatment in an effort to reduce the risk of diffuse lamellar keratitis (DKL) which may become visually significant due to corneal scarring, irregular astigmatism, and corneal melting.

Initials _____

4. I understand that, following LASIK, the superficial skin cell layer (epithelium) may grow and proliferate in the space between the corneal flap and the cornea. This may happen days, weeks, or even months following LASIK. If progressive, this may lead to corneal flap swelling and decompensation, irregular astigmatism, loss of vision, and the need for further surgery including, but not limited to, lifting the flap to remove the epithelial ingrowth. This condition is quite uncommon and is usually successfully treated in the vast majority of cases.
5. I understand that irregular healing of the LASIK flap, including wrinkles (striae) in the corneal flap, could result in a distorted cornea. This would mean that glasses or contact lenses may not correct my vision to the level possible before undergoing LASIK. If this distortion in vision is severe, a partial or complete corneal transplant might be necessary to repair the cornea.
6. I understand it is possible that a perforation of the cornea could occur during LASIK, causing devastating complications, including loss of some or all of my vision. This could also be caused by an internal or external eye infection that may not be controlled with antibiotics or other means.
7. I understand that mild or severe infection is possible following either LASIK or PRK. Mild infection can usually be treated with antibiotics and usually does not lead to permanent visual loss. Severe infection, even if successfully treated with antibiotics, could lead to permanent scarring and loss of vision that may require corrective laser surgery or, if very severe, corneal transplantation.
8. I understand that scar tissue (“haze”) can form on the surface of the cornea following PRK surgery, causing loss or distortion of vision or night time visual complaints in severe cases. I understand that all patients are at risk of haze formation, and that the risk is proportional to the degree of nearsightedness or farsightedness treated with the laser. I understand that the risk of haze formation can be minimized to a certain degree by wearing protective sunglasses while outdoors for the first four months following surgery, and by using topical steroid eye medications as instructed. I understand that my surgeon may suggest the use of intraoperative Mitomycin-C in an attempt to prevent corneal scarring.
9. I understand that topical steroid eye medications are routinely prescribed following LASIK and PRK, and that these medications have rare, but potentially significant, side effects, including cataract formation, intraocular pressure elevation (with potential for glaucoma damage), and increased risk of infection. I understand the importance of attending all of my scheduled post-operative appointments so that I can be evaluated for all of these possible side effects.
10. I understand that other very rare complications include, but are not limited to, corneal swelling, progressive corneal thinning (ectasia), appearance of “floaters” and retinal detachment, hemorrhage, retinal vein/artery blockage, glaucoma, cataract formation, total blindness, and even loss of my eye. I understand that, although I have been screened for pre-existing corneal pathology that may lead to progressive vision loss, even patients with “normal” screening exams may later present with signs of eye disease (e.g. Keratoconus).

NON-VISION THREATENING SIDE EFFECTS

1. Blurriness is common in the healing process following LASIK and PRK. I understand that my visual acuity will generally be stable by 2-3 months after PRK, and 2-3 weeks after LASIK.
2. I understand that there may be increased sensitivity to light, flare, and fluctuations in the sharpness of vision. I understand these conditions usually occur during the period of one to three months after surgery, but they may rarely be permanent.
3. Following LASIK and PRK, there will be varying degrees of discomfort/ pain, feeling of something in the eye, tearing, swelling of the eyelids, and redness of the eye. These are associated with the normal post-treatment healing process, and should be expected to last from 1-2 days with LASIK, and 3-6 days with PRK, though it may last longer. Bruising of the eye may last for several weeks, but resolves spontaneously.

Initials _____

4. I understand there may be a decrease in contrast sensitivity, or a decrease in the overall sharpness and quality of vision, despite excellent visual acuity.
5. I understand that there is an increased risk of eye irritation related to drying of the corneal surface following PRK or LASIK. . These symptoms may be temporary or, on rare occasions permanent, and may require frequent application of artificial tears and/or closure of the tear duct openings in the eyelid. I understand that I may suffer from dry eye symptoms after surgery even if I did not experience these symptoms prior to surgery.
6. I understand that an overcorrection or under-correction could occur, causing me to have residual refractive error (being farsighted, nearsighted, or having astigmatism). This could be either permanent or treatable. I understand an overcorrection or under-correction is more likely in people over the age of 40 years and may require the use of glasses for reading or for distance vision some or all of the time. I understand that there are situations after surgery that may prevent my surgeon from being able to perform an enhancement to decrease my residual refractive error.
7. I understand that at night there may be a “starbursting” or halo effect around lights. I understand that this condition usually diminishes with time, but could be permanent. I understand that my vision may not seem as sharp at night as during the day and that I may need to wear glasses at night. I understand that I should not drive until my vision is adequate both during the day and at night.
8. I understand that I may not get a full correction from my LASIK and PRK procedure and this may require future enhancement procedures, such as more laser treatment or the use of glasses or contact lenses.
9. I understand that there may be a “balance” problem between my two eyes after LASIK or PRK has been performed on one eye, but not the other. This phenomenon is called anisometropia. I understand this would cause eyestrain and make judging distance or depth perception more difficult. I understand that my first eye may take longer to heal than usual, prolonging the time I could experience anisometropia.
10. I understand that, after LASIK, the eye may be more fragile to trauma from impact. Evidence has shown that the corneal incision will not be as strong as the cornea originally was at that site. I understand that the treated eye may be slightly more vulnerable to injury. I understand that it is important for me to wear protective eyewear when engaging in sports or other activities in which the possibility of a ball, projectile, elbow, fist, or other traumatizing object contacting the eye may be high.
11. I understand that there is a natural tendency of the eyelids to droop with age and that eye surgery may hasten this process.
12. I understand that, following PRK, a bandage soft-contact lens will be placed onto the eye where it will remain for 4-5 days, or until the epithelium has healed. I understand that this is not an FDA-approved use of the contact lens, and that it slightly increases the risk of infection. I understand the contact lens is placed to decrease post-operative discomfort and improve healing time. Should the contact lens fall out of the eye, there will be an expected increase in pain. I will inform my doctor if I do not want a contact lens used after surgery.
13. I understand that temporary glasses either for distance or reading may be necessary while healing occurs and that more than one pair of glasses may be needed.
14. I understand that there are very long-term effects of LASIK and PRK which may be unknown at this time and that unforeseen complications or side effects could possibly occur.
15. I understand that my visual acuity after LASIK or PRK could regress, and that my vision may partially regress to a level that may require glasses, contact lenses or enhancement surgery to see clearly.

Initials_____

16. I understand that the correction that I can expect to gain from LASIK or PRK may not be “perfect”. I understand that it is not realistic to expect that this procedure will result in perfect vision at all times, under all circumstances, for the rest of my life. I understand I may need glasses to refine my vision for some purposes requiring fine detailed vision at some point in my life, and that this could occur either soon after surgery, or years later.
17. I understand that I may be given medication in conjunction with the procedure and that my eye may be patched afterward. I understand that I must not drive the day of surgery. I understand that I should not drive until my surgeon gives me clearance based on my visual acuity and the requirements of the state. I understand that, although I may be “legal” to drive, I should not drive or operate heavy machinery until I feel comfortable that my vision is adequate. I understand that I must not drive while taking narcotic pain medications or sedatives, or for at least 24 hours following the last dose of these medications.
18. I understand that if I currently need reading glasses, I will still likely need reading glasses after this treatment. It is possible that dependence on reading glasses may increase or that reading glasses may be required at an earlier age if I have this surgery.
19. Enhancement surgeries can be performed when vision is stable UNLESS it is unwise or unsafe. After LASIK the flap can usually be lifted with specialized techniques. After 6 months of healing, a new LASIK incision **may be** required, incurring greater risk. In order to perform an enhancement surgery, there must be adequate tissue remaining. If there is inadequate tissue, it may not be possible to perform an enhancement. An assessment and consultation will be held with the surgeon at which time the benefits and risks of an enhancement surgery will be discussed.
20. I understand that, as with all types of surgery, there is a possibility of complications due to anesthesia, drug reactions, or other factors that may involve other parts of my body. I understand that, since it is impossible to state every complication that may occur as a result of any surgery, the list of complications in this form may not be complete.
21. I understand that LASIK and/or PRK may be contraindicated for individuals with certain medical conditions (including, but not limited, to vascular disease, uncontrolled diabetes, HIV+ status, autoimmune disease, or immunocompromised states) or ocular conditions (including, but not limited to, keratoconus, irregular astigmatism, thin corneas, history of herpes simplex keratitis, cataract, glaucoma). I understand that certain medications (including, but not limited to Accutane, Amiodarone, Imitrex) may affect my healing response and predispose me to corneal scarring, poor wound healing or infection.

I understand that it is not possible to state every complication that may occur as a result of LASIK or PRK surgery. I also understand that complications, or a poor outcome, may manifest weeks, months or even years after LASIK or PRK surgery.

FOR WOMEN ONLY: I am not pregnant or nursing, and have not been pregnant or nursing within the past six months. I understand that pregnancy or nursing could adversely affect my treatment results. I also understand that I should not become pregnant while taking steroid eye drops post-operatively, which may last up to three months after surgery.

FOR PRESBYOPIC PATIENTS (those requiring a separate prescription for reading): The option of monovision has been discussed with my ophthalmologist.

Initials_____

SPECIAL MILITARY CONSIDERATIONS:

1. Smallpox vaccine: I understand that LASIK or PRK should not be performed on an individual within a minimum of three weeks after smallpox vaccination. I also understand that individuals who are currently taking topical steroid eye drops following LASIK or PRK should not receive the smallpox vaccine until their steroid course is completed.
2. I understand that LASIK is disqualifying for attending an USASOC-sponsored schools such as HALO, SCUBA, Special Forces Qualification course, SERE, and certain ARSOF units. PRK is allowed for Special Operations personnel, and LASIK may be available if granted a waiver obtained through the appropriate command. Soldiers who are interested in Special Operations should NOT undergo LASIK treatment for any reason unless a waiver is granted. I also understand that personnel on flight status or receiving flight pay may not be allowed to have refractive surgery, and may lose their flight status and flight pay if they do. I also understand that the surgery may disqualify me from commissioning or certain occupations such as aviation. I understand that it is my responsibility to contact the medical department of my current/prospective Aviation, Special Operations, Diving unit to confirm eligibility for refractive surgery prior to proceeding with refractive surgery. Radial keratotomy, an alternative to LASIK or PRK, is not allowed for any active duty personnel.
3. I understand that if my vision after surgery should fall outside the minimum acceptable for my job that I may be required to change my rate/designation, and that I may be referred for a medical evaluation board. As this is considered elective surgery, should I be separated from the service due to any complication that results from my surgery, I understand that I may not receive any benefits related to the surgery.
4. If I suffer any injury directly related to my surgery I understand that I should seek immediate medical attention at the nearest military medical treatment facility. I understand that although no financial compensation is available, any injury resulting from my surgery will be evaluated and treated in keeping with the benefits of care to which I am entitled under applicable Army, other Department of Defense, and other state or federal regulations.

BILATERAL SURGERY CONSIDERATIONS:

I understand that, should I choose to have both eyes treated at the same surgical setting for added convenience, that there may be risks associated with simultaneous treatment that are not present when the eyes are treated on different days. These risks include, but are not limited to, infection and accuracy of final outcome.

PATIENT'S STATEMENT OF ACCEPTANCE AND UNDERSTANDING

The details of the procedure known as LASIK and PRK have been presented to me in detail in this document and explained to me by an eye doctor. My doctor has answered all my questions to my satisfaction and I therefore consent to LASIK or PRK surgery, as indicated.

I give my permission for my ophthalmologist to record on video or photographic equipment my procedure, for purposes of education, research, or training of other health care professionals. I also give my permission for my ophthalmologist to use data about my procedure and subsequent treatment to further understand LASIK and PRK, but I also understand that no patient identifiers will be used in this capacity.

Initials _____

Appointment Communication Log

Rank:	Name:	Branch:	Last 4:	DOB:
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Commander's Ltr Dated: _____ DEROS/PRD: _____ ETS/EAOS Date: _____

Signature Block: _____ Re-enlistment/Extension/Deployment paperwork: _____

Assumption of Command /By Direction Memo: _____

Air Force Commander's Authorization "Warfighter" form: _____ Date of Eye Exam/RX: _____

Patient Learning Form: _____ TAMC Clinic Con Leave Form: _____

Combo Eval Date: _____ Instructions Given: _____

Pre-Op Counseling: _____ @ _____ **Visual Field:** _____ @ _____

Surgery: _____ @ _____ **PRK / LASIK / MMC SCRAPE OD / OS / OU**

Surgeon: _____

1 Day Post-Op: _____ @ _____ **4 / 5 Day Post-Op:** _____ @ _____

Surgery Completed: _____ **PRK / LASIK / MMC SCRAPE OD / OS / OU**

Surgeon: _____

Enhancement Date: _____ **OD / OS / OU** **By: Dr.** _____

DATE:	TIME:	APPT TYPE:	DOCTOR:
_____	@ _____	_____	_____
_____	@ _____	_____	_____
_____	@ _____	_____	_____
_____	@ _____	_____	_____

Acknowledgement of Military Health System Notice of Privacy Practices

The signature below only acknowledges receipt of the Military Health System Notice of Privacy Practices, effective date 14 April 2003.

→	Signature of Patient/Patient Representative	Date
→	Printed Name of Patient/Representative Relationship to Patient(if Applicable)	
→	FMP/SSN: 20 / - -	
_____ Patient/Representative Declined to Sign _____ MTF Staff Initials		