TRIPLER ARMY MEDICAL CENTER - REFRACTIVE SURGERY CENTER (RSC)

REFRACTIVE SURGERY PACKET - OVERSEAS/OUTER ISLAND PATIENTS

NAME: ____________________________________________ DATE: ______________
LODGING ON ISLAND (if known): __________________________
CONTACTINFOWHILEONOAHU (PHONE/EMAIL): __________________________

AFTER READING THIS ENTIRE PACKE YOU SHOULD COMPLETE ALL HIGHLIGHTED AREAS, SCAN THE ENTIRE PACKET AND EMAIL IT TO:
Usarmy.tripler.medcom-tamc.mbx.ds-refractive-surgery@mail.mil

Please read the following instructions to help expedite the process:

· Print the appropriate Commander’s Authorization Letter. Route this through your chain-of-command. You can scan and email this packet prior to having your Command Authorization signed, but we will require a scanned/emailed copy prior to confirming your evaluation date at our center.
· Have your local Ophthalmologist or Optometrist complete the Certification Letter for Refractive Surgery Post-Operative Care (listed below). The signed form must be scanned and emailed with this packet.
· Complete ALL of the highlighted areas on this entire Refractive Surgery Packet
· Locate a copy of any Eye Exam less than 3 years old, along with a Glasses or Contact Lens Prescription that is at least one year old. Scan both of these, along with your completed Refractive Packet, and email all three items to the address noted at the top of this page.
· DO NOT scan and email this packet unless it is complete
· We will contact you after we receive your completed packet. Due to the very busy nature of our Center, it may take 1-2 weeks until you hear from us--please be patient. Please email us if you haven’t heard from our Center after two weeks.
· After we receive your completed packet we will have our surgeons review the packet for preliminary approval. If approved, and we have a copy of your signed Command Authorization, we will email you with potential dates for your Comprehensive Refractive Evaluation (CRE) at our Center. If you are considered a good surgical candidate, we will arrange for your surgery within a week of your CRE. We will provide more information in future emails.

Mahalo,

The Staff at the TAMC Refractive Surgery Center
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 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 plan to remain on island for at least 1 week after PRK or LASIK, or longer for ICL or Refractive Lens Exchange surgery. If necessary, I may need to stay on Oahu for longer than this period of time.

[ ] 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 am responsible for arranging, and paying for, travel/meals/lodging while on Oahu.

[ ] I understand that I must bring the following items with me when I have my Comprehensive refractive evaluation at Tripler RSC: military ID, original refractive packet and Command Authorization, current glasses and any available spectacle/contact lens prescriptions.

[ ] (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.

[ ] I understand that I will not be able to have surgery if I miss any pre-operative exams. I understand that it is advisable to have a companion to assist me during the initial post-operative period.

[ ] 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 verified that adequate post-operative care is available in my local area and I will complete all follow-up care as noted on the Certification Letter for Refractive Surgery Post-Operative Care (enclosed)

[ ] 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 should not have TDY/Deployment/PCS for approximately 3 months after PRK/ICL/Refractive Lens Exchange, or 1 month after LASIK, unless determined otherwise by my treating surgeon (Ophthalmologist).

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Service member’s printed name __________________________ Signature __________________________ Date __________________________
TRIPLER ARMY MEDICAL CENTER - REFRACTIVE SURGERY CENTER

Appointment Communication Log

Commander’s Ltr Dated: ____________ DEROS/PRD: ____________ ETS/EAOS Date: ____________

Assumption of Command /By Direction Memo: ____________ Verifying Document: ____________

Air Force Commander’s Authorization “Warfighter” form: ____________ Exp: ____________
Training/Underway __________________________
Deployment __________________________
Leave __________________________
PCS __________________________

Re-enlistment/Extension/Deployment paperwork: ____________
Verified by: ____________

Date of Eye Exam/RX: __________________________

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

Initial Eval: __________________________

Doctor’s Eval: __________________________

Surgery: __________________________@_______PRK / LASIK OD / OS / OU

Surgeon: __________________________

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

Surgery Completed: __________________________PRK / LASIK OD / OS / OU

Surgeon: __________________________

DATE: __________________________ @ __________________________ TIME: __________________________ APPT TYPE: __________________________ DOCTOR: __________________________
Patient Questionnaire

Please fill out completely:

Date: ________________ DOD ID #: __________________

Name: ___________________________ Rank/Grade: __________ Branch: _______
   (Last) (First) (MI)

Age: ____ Date of birth: DD / Month / YY Gender: ☐ Male ☐ Female
   (Example: 01 Jan 80)

MOS/Occupation: ________________ Unit: _____________________

Home Address: _________________________________________________

Phone number: Home: ______________ Work: _______________
   Cell: __________________________

Email address: _________________________________

Are you going on any type of Training, Leave, or Deployment?
   Training/Underway ________________________________
   Leave ___________________________________________
   Deployment ______________________________________

Are you undergoing a medical board or disability evaluation or on LIMDU? Yes or No

Are you going to PCS in the next 12 months? Yes or No When? ________________

In your own words, please list what your expectations are for refractive surgery:
   Example: To be able to wake up in the morning and see the clock.

   1. ___________________________________________________________
   2. ___________________________________________________________

Military Duties:
Are you involved in or expecting to apply for flight status or special operations? Yes or No

Are you involved in or expecting to apply for submarine/undersea duty? Yes or No

Are you deploying to a combat zone within the next TWELVE months? Yes or No

If so, estimated date deploying? ________________________________
Name: ___________________________ Date of birth: ____________ Last 4: ______ (Last) (First) (MI) (Example: 01 Jan 80)

Medical and Ocular History:
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? ______________
Do you wear contact lenses? Yes or No
If so, how many years ______________, how many hours a day ______________
Type of contacts: Disposable Soft Daily wear Soft Extended wear Soft toric (to correct astigmatism) Hard contacts Unsure Other ______________
Date last worn: ______________
How long has your contact lens prescription been unchanged? ______________

Please circle your answer to the following questions.
(Scale: 0 - None, 1 - Minimal, 2 - Mild, 3 - Moderate, 4 - Severe, 5 - Extreme)

Do you have dry eyes? 0 – 1 – 2 – 3 – 4 – 5
Do you have glare or halos? 0 – 1 – 2 – 3 – 4 – 5

Quality of your vision with correction during:
Daytime: Excellent Very good Good Fair Poor
Nighttime: Excellent Very good Good Fair Poor

Overall satisfaction of your vision:
Without correction: Very satisfied Moderately satisfied Mildly satisfied Dissatisfied
With glasses: Very satisfied Moderately satisfied Mildly satisfied Dissatisfied
With contacts: Very satisfied Moderately satisfied Mildly satisfied Dissatisfied

List all medications or supplements you take regularly: ______________________________

List any allergies (medication, food, seasonal) that you have: ______________________________

FEMALES:
Are you pregnant or have you been pregnant in the last 6 months? Yes / No
Have you been breastfeeding in the past 6 months? Yes / No
Has a doctor ever told you that you have? (If you don’t know what it is, just skip it.)
Please circle YES or NO to the following questions:

1. Corneal disease? YES NO
2. Glaucoma/ High eye pressure? YES NO
3. Amblyopia/ Lazy eye? YES NO
4. Retinal problems? YES NO
5. Recurrent eye inflammation or uveitis? YES NO
6. Herpes infection in your eyes? YES NO
7. Keratoconus/ progressive corneal thinning? YES NO
8. Cataract? YES NO
9. Eye injury? YES NO
10. Eye infection? YES NO
11. Eye ulcer? YES NO
12. Eye surgery, including PRK or LASIK? YES NO
13. Diabetes? YES NO
14. Autoimmune disease? YES NO
15. Keloid formation? YES NO
16. Immune compromise? YES NO
17. Skin eczema/ Atopy/ Allergies? YES NO
18. Accutane, Amiodarone, or Imitrex use? YES NO
19. Other medical conditions? YES NO

If YES to any of the above, explain here.


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: COMMANDER’S PERMISSION FOR REFRACTIVE SURGERY

TAMC Refractive Eye Surgery Center, Phone 808-433-3089
This Soldier is interested in eye surgery to reduce his/her need for corrective lenses.

Rank _______ Name ___________________ Last Four SSN _______ MOS Type _______ [ ] Combat Arms
[ ] NonCombat Arms

1. This soldier’s earliest potential deployment date is _________ (DDMMYY)

2. Required Army obligation:
   a. Soldier has at least 6 months remaining on active duty. End of obligated service date: _________ (MM/YY)
   b. Soldier MUST provide copy of SRB.
   c. Soldier is not scheduled to PCS in the next 6 months
   d. Soldier has no adverse personnel actions pending and is not undergoing med board process.
   e. Soldier will not deploy for at least 90 days after PRK (corneal laser surgery)
   f. Soldier will not deploy for at least 30 days after LASIK (corneal laser surgery)
   g. Soldier will not deploy for at least 30 days after ICL (intraocular collamer lens) implantation surgery

3. After refractive surgery this soldier will get a temporary profile to which the undersigned will adhere:
   a. No organized PT for 30 days
   b. No field or sea duty for 30 days
   c. No wearing of protective NBC mask or face paint for 30 days
   d. No swimming, airborne jumping, firing weapons, or driving military vehicles for 30 days
   e. Sunglasses should be worn outdoors & in bright lights for one year after PRK
   f. No gas chamber or OC spray training for 6 months after PRK; 3 months after LASIK or ICL surgery
   g. No deployments for 3 months after PRK; 1 month after LASIK or ICL surgery
   h. Convalescent leave will be given: 5 days for PRK or ICL surgery; 3 days for LASIK

4. This soldier will make all follow-up appointments to ensure proper healing. Minimum appointments required:
   a. PRK: 1 week/ 1 month/ 3 months
   b. LASIK: 1 day/ 1 week/ 1 month
   c. ICL: 1 day/ 1 week/ 1 month/ 3 months

5. The undersigned will notify the Refractive Surgery Center immediately if the soldier’s circumstances change and he/she no longer meets the above criteria.

6. This endorsement is valid for 6 months. If surgery cannot be performed within the next 6 months a new endorsement must be completed by the soldiers and commander(s).

7. By signing below you agree to comply with all the above statements. See our website for more information concerning PRK and LASIK at TAMC, http://tamc.amedd.army.mil/offices/Ophthalmology

Soldier’s Signature ______________________________________________________

Commander Signature Block

Signature _________________________________________________________________

Print Name _______________________________________________________________

Phone Number _____________________________________________________________

Email address ______________________________________________________________________________________

Date of Signature ____________________________ (Continue on reverse)

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)
Commander’s Permission for Refractive Surgery

- **Must** be dated within 6 months of surgery date
- **Must** have an O-3 or higher Commanding Officer/Company/Commander sign
- For all service members, if someone other than the above listed persons signs for the commander, a “By Direction” or “Assumption of Command” memo must accompany your Commander’s Letter.
- NO “scratch-outs” “write-overs” or white out. **Forms with errors will not be accepted.**

Deployment Memo

- If deploying in the next 12 months: memo from your supervisor with your deployment dates is required

**Completed Commander’s Permission Forms are required prior to scheduling the preoperative evaluation with the Laser Center optometrist.**
This member is interested in eye surgery to reduce his/her need for corrective lenses.

Rank_________________________Name_________________________Last Four SSN________________________

1. This member’s earliest potential deployment date is __________(DDMMYY)

2. Required USN/USMC/USCG obligation:
   a. Member has at least 12 months remaining on active duty. End of obligated service date: __________(MM/YY)
   b. Member MUST provide copy of their ERB/ORB/LES
   c. Member is not scheduled to PCS in the next 6 months
   d. Member has no adverse personnel actions pending and is not undergoing a medical board process.
   e. Member will not deploy for at least 90 days after PRK (corneal laser surgery)
   f. Member will not deploy for at least 30 days after LASIK (corneal laser surgery)
   g. Member will not deploy for at least 30 days after ICL (intraocular collamer lens) implantation surgery

3. After refractive surgery this member will get a temporary profile to which the undersigned will adhere:
   a. No organized PT for 30 days
   b. No field or sea duty for 30 days
   c. No wearing of protective NBC mask or face paint for 30 days
   d. No swimming, airborne jumping, firing weapons, or driving military vehicles for 30 days
   e. Sunglasses should be worn outdoors & in bright lights for one year after PRK
   f. No gas chamber or OC spray training for 6 months after PRK; 3 months after LASIK or ICL surgery
   g. No deployments for 3 months after PRK; 1 month after LASIK or ICL surgery
   h. Convalescent leave will be given: 5 days for PRK or ICL surgery; 3 days for LASIK

4. This member will make all follow-up appointments to ensure proper healing. Minimum appointments required:
   a. PRK: 1 week/ 1 month/ 3 months
   b. LASIK: 1 day/ 1 week/ 1 month
   c. ICL: 1 day/ 1 week/ 1 month/ 3 months

5. The undersigned will notify the Refractive Surgery Center immediately if the member’s circumstances change and he/she no longer meets the above criteria.

6. This endorsement is valid for 6 months. If surgery cannot be performed within the next 6 months a new endorsement must be completed by the members and commander(s).

7. By signing below you agree to comply with all the above statements. See our website for more information concerning PRK and LASIK at TAMC, http://tamc.amedd.army.mil/offices/Ophthalmology

Member Signature

Commander Signature Block

Signature

Print Name

Phone Number

Email address

Date of Signature

(Continue on reverse)
Commander’s Permission for Refractive Surgery

- **Must** be dated within 6 months of surgery date
- **Must** have an O-3 or higher Commanding Officer/Company Commander sign
- For all service members, if someone other than the above listed persons signs for the commander, a **By Direction or Assumption of Command memo** must accompany your Commander’s Letter.
- No copies accepted. Originals only. No “scratch-outs, write-overs” or white out.

Deployment Memo

- If deploying in the next 12 months: memo from your supervisor with your deployment dates is required

**Completed Commander’s Permission Forms are required prior to scheduling the preoperative evaluation with the Laser Center optometrist.**