Landstuhl Regional Medical Center (LRMC) Warfighter Refractive Eye Surgery Program (WRESP)

ARMY Checklist

1.	Read through Clinical Guidelines paying close attention to the retention requirements and complete attached documents. ☐ Commander's Authorization Memo (must be signed by the battalion commander. If commander is unavailable, the first officer in the chain of command on **G-series** orders is authorized to sign.) ☐ Managed Care Agreement ☐ Patient Information Sheet (DA Form 4700) ☐ MEDCOM Form 756--granting LRMC WRESP permission to email patients with appointment information. **All correspondence must be done via government email addresses.**
2.	For members who wear contact lenses: ☐ No soft contact lenses wear at least 30 days prior to pre-op appointment. ☐ No rigid gas permeable (hard) contact lenses wear at least 90 days prior to pre-op appointment.
3.	☐ Member must complete pre-operative evaluation with base optometry.
4.	☐ Email or Drop off signed Commander's Authorization Memo, managed care agreement, Patient Information Sheet & MEDCOM Form 756 to WRESP. usarmy.landstuhl.medcom-ermc.list.lrmc-wresp@mail.mil WRESP office located @ LRMC in 11B Room 101. ☐ Contact our office at least 48 hours after you have been referred by your local Optometry clinic. DSN: 590-6361 or CIV: 06371-9464-6361 Mon-Thurs 0800-1500/Friday 0800-1200 * Closed Training Holidays and Federal Holidays* Reminders: remember to keep a copy of all signed paperwork for your own records.
5.	☐ A total of 5 appointments are MANDATORY at LRMC. • Pre-operative appointment @ Landstuhl • Briefing appointment • Surgery appointment • 1 day post operative appointment-- receives convalescent leave paperwork • 1 week post operative appointment-- receives profile **NOTE: You must have an escort/driver on the day of your surgery, 1 day, and 1 week follow-up appointments.** ****You can be disqualified for surgery anytime up to the day of the procedure****
6.	Member completes follow-up evaluations with co-manager clinic (base optometry). ☐ 1 month post-op ☐ 3 month post-op ☐ 6 month post-op (Member will be dilated at this visit; driver is required.) ☐ 12 month post-op

LANDSTUHL REGIONAL MEDICAL CENTER

Warfighter Refractive Eye Surgery Program

Clinical Guidelines

PLEASE NOTE: THESE ARE REFERRAL GUIDELINES. EACH SURGERY IS INDIVIDUALLY PLANNED AND THEREFORE REGARDLESS OF CRITERIA SOME PATIENTS MAY NOT BE OFFERED CERTAIN PROCEDURES. PLEASE DO NOT REFER ANY PATIENTS TO US FOR REFRACTIVE SURGERY IF THEY DO NOT MEET THE BELOW GUIDELINES.

1. ADMINISTRATIVE GUIDELINES

   - **STATUS:** Active Duty and Activated Reservist (currently on "active duty")
   - **AGE LIMIT: 21**
   - **RETENTION CRITERIA** (TIME REMAINING ON ACTIVE DUTY AFTER SURGERY DATE):
     - ARMY ACTIVE DUTY: 6 months
     - NAVY/MARINE ACTIVE DUTY: 12 months
     - AIR FORCE ACTIVE DUTY: 6 months
     - RESERVISTS ON ACTIVE DUTY: Service standards
   - DEPLOYMENTS: No scheduled deployments within 3 months of surgery
   - COMMANDER'S AUTHORIZATION[1]: Valid for 6 months
   - SMALLPOX IMMUNIZATION: no laser treatments within 3 weeks of smallpox immunization (Ask); no immunization up to 4 months after laser treatment[2]
   - OPTOMETRY POST-OPERATIVE CARE: Optometrist must be within 2 hours of patient's duty location; Patient must have a managed care agreement unless LRMC is providing post-op care. If member is PCSing within 90 Days after surgery a new MCA must be completed by the gaining unit Optometrist.

2. PRE-OPERATIVE UNCORRECTED DISTANCE VISUAL ACUITY:
   - MYOPE: 20/40 OR WORSE
   - HYPEROPE: NO MINIMUM

3. CONTACT LENS WEARERS:
   - Soft Contact lenses must be out 30 Days prior and Hard Contacts 90 Days prior to pre-operative evaluation at Landstuhl. DO NOT RESUME (HARD OR SOFT) CONTACT LENS AT ANY TIME PRIOR TO TREATMENT. This can greatly affect treatment accuracy!

4. REFRACTIVE LIMITS:
   - Myopia: -0.75D to -8.00D SE (PRK)
     -0.75D to -11.00D SE (LASIK)
   - Hyperopia: +0.75D to +3.00D SE

5. WAVELIGHT EX500 REFRACTIVE LIMITS (FDA):
   - Myopia: Sphere up to -12.00D LASIK and -6.00 PRK with cylinder ≤ 6.00D LASIK and ≤ 3.00 PRK
   - Hyperopia: up to +6.00D sphere; cylinder ≤ 5.00D (LASIK)
   - Mixed astigmatism: Cylinder up to 6.00 D (LASIK) when magnitude of cylinder > sphere and opposite sign

6. PACHS (Pentacam):
   - PRK: ≥ 475 microns; no thinner than 350 microns residual bed
   - LASIK: ≥ 500 microns; no thinner than 300 microns residual bed

7. K's:
   - Post-op K's of 35.0D and above is acceptable (Steep K – MR Sphere = postop K)
   - No refractive surgery for pre-op K's of <40D or >48D

8. REFRACTIVE STABILIZATION:
   - **Must have MRx over 1 year old to show stable Rx**
   - **No more than 0.5D shift in sphere or cylinder over the past year**
   - **If not stable, bring back in 3 months for repeat MRx and CRx**
   - **CRx needs to be done with Cyclopentolate and is good for 6 months**

9. SYSTEMIC CONDITIONS THAT ARE DQ
   - Autoimmune Diseases[3]
   - Immunodeficiency Diseases (AIDS/HIV)
   - Pregnancy- must be 6 months post-partum
   - Breastfeeding- nursing discontinued for 6 months
   - Diabetes
   - *Keloid formers are OK

10. OCULAR CONDITIONS THAT ARE DQ
    - History of Herpetic Eye Disease
    - Keratoconus or Forme-fruste keratoconus
    - Pellucis Marginal Degeneration
    - Ocular Rosacea
    - Severe Dry Eye Disease (e.g. < 10 mm Schirmers)
    - Glaucoma - Pigment Disp Syndrome is not DQ if pt is not on meds and shows no signs of glaucoma
    - Visually significant Corneal Scars

11. MEDS THAT ARE DQ
    - Imitrex : needs to be off for 1 month
    - Accutane: needs to be off 6 months
    - Amiodarone (antiarrhythmic med)
    - TB meds (INH): needs to finish the course
    - Prednisone
    - Any immunosuppressive drug

12. OCCUPATIONAL CONSIDERATIONS
    - AF Aviation and Aviation-related Special Duty (AASD) personnel may be treated at any DoD RS Center with following exception:
      - All hyperopic Pilots and Boom Operators will be evaluated at ACS prior to being treated at JWRSC, Lackland AFB, San Antonio, TX.
    - AF Security Police: PRK recommended

NOTES:

1. Make sure the Commander's Authorization is signed, stamped and dated less than 6 months from the anticipated treatment date. **The COMMANDER'S AUTHORIZATION Form is an important medical document; please do not use white-out.** Please have patient get form resigned if necessary. Once the form is signed and a referral is created, the patient must wait to be contacted by the WRESP clerks. Patients are NOT to call to check on their status unless they are not contacted within 1 week. Patients are contacted by priority when pre-op slots are available for them.

2. **Smallpox Immunization:** Refractive surgery cannot be performed within 3 weeks of smallpox immunization. You should **not** receive this immunization as long as you are still prescribed drops after refractive surgery. This may be as long as four months after surgery. Please reschedule or cancel, if needed.

3. **Examples of Autoimmune Disease (Listed by the Main Target Organ)**

Nervous System:
Multiple Sclerosis
Myasthenia Gravis
Autoimmune neuropathies
Guillain-Barre
Primary biliary cholangitis
Autoimmune uveitis

Blood:
Autoimmune hemolytic anemia
Autoimmune thrombocytopenia
Pernicious anemia

Blood Vessels:
Antiphospholipid syndrome
Vasculitides such as Granulomatosis with polyangitis (i.e. Wegener's dz)
Behcet's disease
Temporal arteritis

Skin:
Dermatitis herpetiformis
Pemphigus vulgaris
Psoriasis
Vitiligo

Endocrine Glands:
Type 1 or immune-mediated diabetes
Type 2 diabetes Mellitus
Autoimmune oophoritis and orchitis
Autoimmune disease of the adrenal gland
Hashimoto's thyroiditis
Grave's Disease

Gastrointestinal System:
Crohn's Disease
Ulcerative Colitis
Autoimmune hepatitis

This document reviewed for accuracy 16 Oct 2021

Abraham Suhr, MD
COL, USA, MC
Director, Warfighter Refractive Eye Surgery Program

LRMC WARFIGHTER REFRACTIVE EYE SURGERY PROGRAM
COMMANDER'S AUTHORIZATION

(1) I give my permission for the following active duty Soldier to be considered for treatment under the Warfighter Refractive Eye Surgery Program (WRESP) and to undergo treatment if eligible.

Applicant Name (Print) (Last / First / MI) Rank DOD ID

(2) I certify the following to be true:

Soldier has at least **6 MONTHS** remaining on **ACTIVE DUTY** before ETS.
Soldier has at least **6 MONTHS** remaining in **country** before PCS.
Soldier has no adverse personnel actions or pending medical boards.
Soldier will not receive any immunizations **30 DAYS** pre-surgery and **90 DAYS** post-surgery.
Soldier will be **NON-DEPLOYABLE** for combat for at least **90 DAYS** post-surgery (30 days for non-combat).

(3) I realize that after refractive surgery the Soldier will be on **CONVALESCENT LEAVE** for **7 DAYS** and will have the following **PHYSICAL PROFILE** for a minimum of **30 DAYS**:

No parachuting, night operations, driving military vehicles or operating heavy machinery
No field, range or other duties involving dirty, dusty, of chemical environments.
No ACFT; member to conduct PT at own pace, duration, and repetitions.
No swimming, scuba, protective mask use or camouflage face paint.
Must wear sunglasses at all times when outdoors to prevent corneal scarring; may wear indoors for comfort.

(4) I acknowledge Soldier is required to complete minimum of 1-day (LASIK), 1-week post-operative exams, 1, 3, and 6-month follow-up exams required by the WRESP; 12-month exam if Soldier is still in country. If PCS after 6 months, soldier to complete the 12-month exam at next duty station.

(5) If scheduled for surgery, members must arrive on time. If the member no-shows for any of the pre-operative appointments, the surgery will be cancelled. High no-show rates from individual units will compromise future members from that unit being scheduled for surgery.
All travel costs will be the responsibility of the service member or unit funded/permissive TDY, as per your unit policies. Member can be medically disqualified at any time up to the day of surgery

(6) Access to DoD laser centers is prioritized according to duty status. Please check one of the following as appropriate for this soldier:

☐ Priority 1: Soldier is assigned to a unit whose mission involves operations at the line of battle or behind hostile lines; special operations and combat arms units such as Infantry, Field Artillery, and Armour Battalions.

☐ Priority 2: Combat Service Support unit personnel and present assignments in a Division or separate Brigade.

☐ Priority 3: other active duty service members.

Battalion Commander's Signature Battalion Commander's Rank and Name (Print) Date

Battalion Commander's Email Address Battalion Commander's Telephone Number

This authorization is valid for 180 days from the date signed by the commander and must be turned in at first appointment. A new authorization will be required after 180 days or if the commander changes. Commander may revoke authorization at his/her discretion. Failure to comply with post-operative requirements may affect future enrollments from this unit.

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

LRMC WRESP PATIENT INFORMATION

OTSG APPROVED *(Date)*
(YYYYMMDD)

LAST NAME:			DATE:	
FIRST NAME: MI:			AFSC/MOS/RATE:	AIR FORCE ONLY: PRP OR FLYER
SOCIAL SECURITY NUMBER:			CURRENT ADDRESS:	
RANK:				
STATUS:	GENDER: M OR F	DUTY STATION:	CELL PHONE:	HOME PHONE:
DEROS DATE: ETS DATE: (indefinite must be accompanied by a reenlistment or retirement date) REENLISTMENT DATE: (if applicable)	SERVICE:		DUTY PHONE: DSN: COMMERCIAL: DUTY E-MAIL: PERSONAL EMAIL:	
EMERGENCY CONTACT: RELATIONSHIP: EMERGENCY CONTACT PHONE:				

HOW MANY YEARS HAVE YOU WORN GLASSES?	
DO YOU OR HAVE YOU EVER WORN BIFOCALS?	YES OR NO
HOW OLD IS YOUR CURRENT GLASSES PRESCRIPTION?	
HOW MANY YEARS HAVE YOU WORN CONTACT LENSES?	
AMOUNT OF TIME YOU SPEND WEARING GLASSES OR CONTACT LENSES FOR DISTANCE VISION (SELECT ONE):	0% <25% 26-50% 51-75% 75-100%
WHEN DID YOU LAST WEAR CONTACT LENSES? *Note: Soft lenses must be out 30 days prior to your first appointment. Gas perm lenses must be out 90 days prior.	
HAVE YOU EVER HAD DIFFICULTY WITH CONTACT LENS WEAR? (PLEASE DESCRIBE):	
KNOWING THAT THERE CAN BE NO GUARANTEE THAT GLASSES OR CONTACT LENSES WILL NO LONGER BE NECESSARY, WHAT DO YOU HOPE TO ACHIEVE FROM HAVING LASER EYE SURGERY? (DO NOT LEAVE THIS BLANK):	

(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)*	○ HISTORY/PHYSICAL ○ FLOWCHART ○ OTHER EXAMINATION OR EVALUATION ○ OTHER *(Specify)* ○ DIAGNOSTIC STUDIES ○ TREATMENT	

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

LRMC WRESP PATIENT INFORMATION

OTSG APPROVED *(Date)*
(YYYYMMDD)

EYE HISTORY:

DO YOU OR HAVE EVER HAD THE FOLLOWING?
(CHECK AS APPLICABLE & SPECIFY DATES ASSOCIATED WITH THESE CONDITIONS)

- ☐ AMBLYOPIA/LAZY EYE
- ☐ CATARACTS
- ☐ CORNEAL DYSTROPHIES
- ☐ RECURRENT CONJUNCTIVITIS
- ☐ CORNEAL ULCER
- ☐ DOUBLE VISION
- ☐ DRY EYES
- ☐ GLAUCOMA OR HIGH EYE PRESSURE
- ☐ HERPES SIMPLEX/ZOSTER
- ☐ KERATOCONUS
- ☐ RETINAL PROBLEMS
- ☐ EYE INJURY
- ☐ OTHER (SPECIFY)

☐ **NONE OF THE ABOVE**

MEDICAL HISTORY:

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(CHECK AS APPLICABLE)

- ☐ ARTHRITIS
- ☐ BREATHING PROBLEMS
- ☐ DIABETES
- ☐ HEART DISEASE OR PACEMAKER
- ☐ HIGH BLOOD PRESSURE
- ☐ IMMUNOSUPPRESSION/HIV
- ☐ MIGRAINE HEADACHES
- ☐ ANY AUTOIMMUNE DISEASE
- ☐ OTHER MEDICAL PROBLEMS (SPECIFY)

☐ **NONE OF THE ABOVE**

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS?
(LIST MEDICATION AND REACTIONS)

ARE YOU SCHEDULED TO DEPLOY OR GO TO THE FIELD IN THE NEXT 3-4 MONTHS?

DO YOU SMOKE OR CHEW TOBACCO?

HAVE YOU EVER HAD SURGERY OR LASER TREATMENTS ON YOUR EYES?
(SPECIFY)

HAVE YOU EVER HAD A WORK UP FOR LASER EYE SURGERY BEFORE:
If so, when and where?

If yes, why did you **NOT** proceed with surgery?

ARE YOU TAKING OR HAVE YOU TAKEN ANY OF THE FOLLOWING MEDICATIONS?
(CHECK AS APPLICABLE & SPECIFY DATES THE MEDICATION WAS TAKEN)

- ☐ ACCUTANE (ISOTRETINOIN)
- ☐ CORDARONE (AMIODARONE)
- ☐ IMITREX (SUMATRIPTAN)
- ☐ INH (OR OTHER TB MED)
- ☐ AMIODARONE (ANTIARRHYTHMIC MED)
- ☐ PREDNISONE STEROIDS
- ☐ IMMUNOSUPRESSANTS

☐ **NONE OF THE ABOVE**

LIST ANY OTHER MEDICATIONS YOU ARE CURRENTLY TAKING:

FEMALE PATIENTS ONLY:
IN THE PAST SIX MONTHS HAVE YOU BEEN PREGNANT OR BREAST FEEDING?

PATIENT NAME _____

PATIENT SIGNATURE _____

DATE _____

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
- ○ FLOWCHART
- ○ OTHER EXAMINATION OR EVALUATION
- ○ OTHER *(Specify)*
- ○ DIAGNOSTIC STUDIES
- ○ TREATMENT

DA FORM 4700

APD PE v1.01ES

LRMC Warfighter Refractive Eye Surgery Program
Managed Care Agreement

_____ _____ _____
Patient Name (Print) Rank Branch of Service

_____ _____ _____
Military Installation Phone Email

In the next 6 months are you: ☐ Deploying When?_____ ☐ PCS'ing When?_____
☐ Separating When?_____ ☐ Retiring When?_____ ☐ N/A

Refractive Surgery Center: Landstuhl Regional Medical Center (LRMC)

Patient Agreement (initial each statement)

_____ I request to be returned to my local eye clinic for post-operative care following refractive surgery at LRMC Refractive Surgery Center. The Refractive Surgery Center staff will be available for additional consultation as needed.

_____ I will contact my local Optometry Clinic to schedule my 1 month post-operative appointment as soon as I am released from LRMC Refractive Surgery Center.

_____I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by policy. Non-compliance may result 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 cannot deploy or PCS for up to 3 months for Army, Navy and Marines and 3-4 months for Air Force. I understand that I must be evaluated by the optometry clinic prior to being cleared to resume unrestricted duties.

_____If deploying before the 6 month exam is due, I will complete my 1 and 3 month exams then return for a post –operative exam at the completion of my deployment.

_____ _____
Patient Signature Date

Mandatory Post-Operative Appointment Schedule:

Completed at treating surgery center: 1 day, (LASIK only), day 5, 6, or 7 post op (PRK and LASIK)
Completed at local eye clinic: 1, 3, 6, 12 months

Co-Managing Provider's Agreement

I certify that I will manage this patient and accept responsibility for 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.

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

_____ _____ _____ _____
Military Installation Phone Fax Email

FOR ANY QUESTIONS PLEASE CALL:
CIV (+049) 06371-86-6869
Or DSN 486-6869

Updated Mar 2021

MEDICAL RECORD - CONSENT FORM
Authorization To Send And Receive Medical Information By Electronic Mail

For use of this form see, MEDCOM Supplement 1 to AR 40-66; the proponent agency is MCHO

SECTION I - PATIENT DATA

1. NAME (Last, First, Middle Initial)	2. DATE OF BIRTH (YYYYMMDD)	3. SOCIAL SECURITY NUMBER (Last four only)
4. E-MAIL ADDRESS		5. TELEPHONE NUMBER

SECTION II - CONDITIONS FOR USE OF E-MAIL

Health care providers cannot guarantee but will use reasonable means to maintain security and confidentially of electronic mail (E-mail) information sent and received. You must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Healthcare providers will respond within_____.
   Contact the clinic telephonically if you have not received a response after _____.
2. E-mail must be concise. You should schedule an appointment if the issue is complex or sensitive precluding discussion by E-mail.
3. E-mail should not be used for communications regarding sensitive medical conditions such as sexually transmitted diseases. HIV/AIDS, spouse or child abuse, chemical dependency, etc.
4. Medical or dental treatment facility staff may receive and read your messages.
5. E-mails related to health consultation will be copied, pasted, and filed.

SECTION III - RISKS OF USING E-MAIL

Transmitting information by E-mail has risks that you should consider these include, but are not limited to the following risks:

1. E-mails can be intercepted, altered, forwarded. or used without authorization or detection.
2. E-mails can be circulated, forwarded and stored in paper and electronic files.
3. E-mail senders can easily type in the wrong E-mail address.
4. E-mail may be lost due to technical failure during composition, transmission, and/or storage.

SECTION IV - PATIENT GUIDELINES

To communicate by E-mail, the patient shall:

1. Place the category (topic) of the communication in the subject line of the E-mail (for example, appointment, prescription, medical advice, etc.)
2. Include the patient's name, telephone number, family member prefix, and the last 4 numbers of the sponsor's social security number (for example: 30/0858) in the body of the E-mail.
3. Acknowledge receipt of the E-mail when requested to do so by a health care provider.
4. Inform the medical or dental treatment facility of changes in E-mail address by completing a new consent form.
5. Notify the health care provider of any types of information considered by the patient to be inappropriate for E-mail.
6. Take precautions to preserve the confidentiality of E-mail.

SECTION V - PATIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. I consent to the E-mail conditions and agree to abide by the guidelines listed above. I futher understand that this E-mail relationship may be terminated if I repeatedly fail to adhere to these guidelines.

I understand and accept the risks associated with the use of unsecure E-mail communications. I further understand that, as with all means of electronic communication, there may be instances beyond the control of the family and the health care provider where information may be lost or inadvertently exposed, such as during technical failures, acts of God, acts of war, and so forth.

I understand that I have he right to revoke this authorization, in writing, at any time.

By signing this form I acknowledge the privacy risks associated with using E-mail and authorize health care providers to communicate with me or any minor dependent/ward for purpose of medical advice, education, and treatment.

(Date)	SIGNATURE of Patient or Parent/Guardian	RELATIONSHIP (if other than patient)

PATIENT IDENTIFICATION *(For typed or written entries note: Name-last, first, middle initial; hospital or medical facility)*	Patient's Name		Sex
	Year of Birth	Relationship to Sponsor	Component/Status
	Depart/Service	Sponsor's Name	
	Rank/Grade	FMP-SSAN (Last four only)	
	Organization		