LRMC -Warfighter Refractive Eye Surgery Program (WRESP)

CHECKLIST

Read through the clinical guidelines paying close attention to the retention requirements and complete attached documents.

1.	☐ DHA FORM 237 *Note: The Commander's Authorization section must be signed by: -Squadron Commander (Air Force/Space Force/Navy) -Battalion Commander (Army/Marines) If commander is unavailable, the first officer in the chain of command on **G-series orders, or that has assumption of command orders** is authorized to sign. ☐ LRMC Managed Care Agreement ☐ 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 their qualification pre-operative evaluation with base optometry.
4.	☐ Email or Drop off this entire packet to the WRESP office. usarmy.landstuhl.medcom-ermc.list.lrmc-wresp@mail.mil Once ALL above documents have been received, you will be contacted by the WRESP office via phone or email. If you have not been notified within 7 business days, please contact the WRESP office. **DSN: 590-6361 or CIV: 06371-9464-6361** **Packet drop off office hours:** **Monday – Thursday: 0800-1500** **Friday: 0800-1200** 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 at Landstuhl • Briefing appointment • Surgery appointment • 1 day post-operative appointment (LASIK only) • 1 week post-operative appointment-- receives profile (LASIK & PRK) **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****

As of: April 2022

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
Unit 33100
APO AE 09180-3100

MCEU-LSS-OPH

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" orders
- **AGE LIMIT: 21**
- **RETENTION CRITERIA** (TIME REMAINING ON ACTIVE DUTY AFTER SURGERY DATE):

  ARMY ACTIVE DUTY: 6 months
  AIR FORCE ACTIVE DUTY: 6 months
  NAVY/MARINE ACTIVE DUTY: 12 months

  RESERVISTS ON ACTIVE DUTY: Service standards

- **DEPLOYMENTS:** No scheduled deployments within **3** months of surgery
- **COMMANDER'S AUTHORIZATION:** 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 two hours of patient's duty location; Patient must have a managed care agreement unless LRMC is providing post-op care. If member is PCS'ing within 90 days after surgery a MCA must be completed by the gaining unit Optometrist prior to surgery.

2. PRE-OPERATIVE UNCORRECTED DISTANCE VISUAL ACUITY:

   MYOPE: 20/40 OR WORSE
   HYPEROPE: NO MINIMUM

3. CONTACT LENS WEARERS:

- Contact lenses must not be worn prior to the pre-operative evaluation at Landstuhl: **30 Days** prior for soft contact lenses and **90 Days** for gas permeable (aka rigid or hard) lenses. After the pre-operative exam, DO NOT RESUME WEARING 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 -12.00D SE (LASIK)
- Hyperopia: +0.75D to +6.00D SE

5. ALCON EX500 REFRACTIVE LIMITS:

- Myopia: -0.75D to -12.00D SE and cylinder ≤ 6.00D
- Hyperopia: +0.50D to +6.00D SE; cylinder ≤ 5.00D
- Mixed astigmatism: Cylinder between 1.00-6.00D when magnitude of cylinder > sphere and opposite sign

6. PACHS (Pentacam):

- PRK: ≥ 475 microns with ≥ 375 micron residual bed
- LASIK: ≥ 500 microns with ≥ 300 micron residual bed (assume 120 micron flap)

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**
- **No more 15 degrees axis rotation over the past year**
- **If not stable, repeat MRx and CRx in 3 months for**
- **CRx needs to be done with Cyclopentolate and is good for 6 months**

9. DISQUALIFYING SYSTEMIC CONDITIONS

- 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. DISQUALIFYING OCULAR CONDITIONS

- History of Herpetic Eye Disease
- Keratoconus or Forme-fruste keratoconus
- Pellucid 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. DISQUALIFYING MEDS

- 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 WRESP with the 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 steroid eye 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

Abraham Suhr
COL MC
OIC, WRESP

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:	E-1	WORK TEL:	
ON FLIGHT STATUS:	YES	MOBILE TEL:	
UNIT DESIGNATOR:		MOS/AFSC/NEC/Job	
AGE:		CURRENT DUTY STATION AND STATE:	
DOB: *(YYYYMMDD)*			
DOD ID:		DEROS DATE: *(YYYYMMDD)*	
HOME EMAIL:		CURRENT END OF ACTIVE DUTY COMMITMENT: *(YYYYMMDD)*	
WORK EMAIL:			
REQUESTED TREATMENT FACILITY:	LANDSTUHL REGIONAL MEDICAL CENTER, GERMANY		

FACILITY INFORMATION:

LANDSTUHL REGIONAL MEDICAL CENTER
DR. HITZELBERGER STR, LANDSTUHL, 66849

WARFIGHTER REFRACTIVE SURGERY (WRESP)
WARD 11B 1ST FLOOR BLDG 3769
DSN: 314-590-6361
CIV: +49 6371-9494-6361

YOUR MILITARY BRANCH:	OTHER: *(please specify)*
ARMY (USA)	
SERVICE TYPE:	ACTIVE DUTY
Have you had refractive surgery before?	NO
Are you pregnant or nursing?	NO
Have you or a family member been diagnosed with Keratoconus?	NO

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	Patient's Priority Level:	☐ 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?	YES				
			Service information has been validated.	YES				
Full Name of Commanding Officer:			RANK:					
			SIGNATURE:					
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	
OD: 20/	
OS: 20/	

MRx:	Sphere	Cylinder		Axis
OD:			X	
OS:			X	

Hyperopic 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 within 30 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 will remain OCONUS 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.

   d. Referring Provider's Instruction. 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 more year to compare to MRx in section.

3. 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**:

   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)

5. 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.

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 post surgery. 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), 4-5 day post op (PRK)
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: April 2022

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. DOD ID NUMBER
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	SELF 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		