

DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
CMR 402
APO AE 09180

MCEUL-SG-OM

MEMORANDUM FOR AREA COMMANDERS

SUBJECT: WARFIGHTER LASER PROGRAM TREATMENT AUTHORIZATION

1. (Rank) _____ (Name) _____ (SSN) _____ requests evaluation for possible refractive surgery (correction of nearsightedness or farsightedness) at Landstuhl Regional Medical Center (LRMC). The patient will schedule an initial evaluation at his or her local optometry clinic to start the process, if authorized by you.
2. The member must bring this letter to their local optometry clinic before entry into the program. Appropriate candidates will be referred to LRMC for surgery to be performed at a later date. ***Individuals will be required to update this authorization letter if surgery is scheduled for later than six months from the date it is signed.***
3. If scheduled for surgery, please anticipate anywhere from ***four to ten days*** of follow-up appointments at LRMC after the day of surgery, depending on the type of procedure performed. Although highly recommended, patients are not absolutely required to stay in the LRMC area at night during this time. However, they cannot drive themselves to these follow-up appointments until cleared by LRMC Ophthalmology staff and should have arrangements made to be driven to the LRMC ER if problems arise outside of duty hours. ***All travel costs will be the responsibility of the service member or unit-funded / permissive TDY, as per your unit policies.***
4. ***Commanders:*** Please be aware of the considerable operational impact this program may have on your unit. Rigorous long-term follow-up is crucial to protect this important military asset- the vision of our soldiers and airmen. Monthly follow-ups will be performed by your local optometry clinic after surgery. ***DO NOT sign this form if you already know that the patient will not be able to commit to at least three months of scheduled follow-up appointments.*** ***In addition, patients will be given a profile for no field duties, no airborne operations, no night operations, and no swimming for a period of one month after refractive surgery. This profile may be extended in unusual cases with complications. See attached Memorandum regarding recovery time/return to theater for refractive surgery.*** The wear of sunglasses when outdoors for the first year is strongly recommended.

5. If scheduled for surgery, members must arrive on time. If the member is more than 10 minutes late to a pre-operative or surgery day appointment, they will be considered a **No-Show** and their surgery will be cancelled. High **No-Show** rates from individual units will compromise future members from that unit being scheduled for surgery.
6. **Important: Smallpox vaccination cannot be given for up to four months after refractive surgery in some cases (depending on steroid use). Taking waiting time to schedule a procedure into account, we recommend you NOT sign this form if you can predict that the soldier will need smallpox vaccination within six months of the date of signature.**
7. Access to DoD laser centers is prioritized according to duty status. Please check one of the following as appropriate for this soldier (**Must be completed by Commander or his/her designee**) *Note: Commanders have the option of assigning a higher priority to a soldier based on imminent upcoming assignments, if they feel it is in the best interest of the Army. (For example, in the case of a Priority 3 soldier who is moving imminently to a Priority 1 position)*

___ 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 Armor Battalions.

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

___ Priority 3: Other active duty service members.

8. The Warfighter Refractive Eye Surgery Program throughout the Army requires each soldier to have at least twelve months remaining on active duty from the date of surgery.

Soldier's current active duty service commitment: _____

Soldier's current MOS: _____

I hereby authorize the above individual to undergo evaluation for refractive surgery. I understand that all involved travel costs will either be unit-funded or permissive TDY, as appropriate.

 Battalion Commander or Authorized Representative
 (Signature stamp when available)

 Date