

USAF Refractive Surgery (USAF-RS) Program Managed Care Agreement

Patient Name

Rank

USAF USA USN USMC
USCG USPHS NOAA

Military Installation

Phone

E-mail

In the next 6 months, are you: PCSing Separating Retiring Deploying N/A

Refractive Surgery Center: Joint Warfighter, Lackland AFB USAF Academy Wright-Patterson AFB
Keesler AFB Travis AFB Other DoD _____

PATIENT AGREEMENT (initial each statement)

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

_____ I will contact my local Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my surgery date.

_____ I understand that I must comply with and accomplish all required referral and follow-up evaluations as required by USAF 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 can not deploy or PCS for up to 4 months after surgery. I understand that I must be evaluated by the base optometry clinic prior to being cleared to resume unrestricted duties.

_____ I understand that I must bring the package of all pre-operative evaluations, surgical reports, and follow-up exams provided by the Refractive Surgery Center to my local optometry clinic for inclusion in my military medical records.

Patient Signature

Date

Post-Operative Appointment Schedule:

AASD: 1, 3, 6, 12, and 24 months, 4 years and then every 5 years

Warfighter: 1, 3, 6, 12 months

Note: ASA (PRK, LASEK, Epi-LASIK, WFG-PRK) requires a 2 month pressure check

REFERRING DOCTOR'S AGREEMENT

I certify that I have attended the USAF-RS Co-Management Course. 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.

Referring Optometrist Stamp/Signature

Date

Military Installation

Phone

Fax

E-mail