Refractive Eye Surgery Application
Warfighter Refractive Eye Surgery Program (WRESP)

(Read instructions completely before filling out application)

Instructions:

1. ***All information must be typed or printed legibly.***
2. ***Enter all dates in the format dd mmm yyyy (example: 01 AUG 2020).***
3. ***NO CONTACT LENS WEAR for a minimum of 30 days prior to preoperative evaluation, and through the surgery date.***
4. ***LASIK and PRK are deemed safe for aviation, Airborne, Air Assault, Ranger and Special Operations schools so long as other visual standards are met.****
5. ***Ranger school applicants require a waiver if the procedure is completed within 3 months of course start date.****
6. ***Soldiers are advised to contact their unit surgeon or other program waiver authorities to determine if any additional waivers or authorizations are required before receiving surgery.***

****IAW OTSG/MEDCOM Policy Memo 20-039***
*****Please include your STP/ERB/ORB with application***

WRESP Center Location
Irwin Army Community Hospital
650 Huebner Rd.
Fort Riley, KS 66442

a. Last Name:	First Name:	MI:	b. Rank / Grade:	c. Date of Application:

d. DoD ID:	e. Date of Birth:	f. Age:	g. Sex: ☐M ☐F	h. MOS / AOC:	i. ETS Date	j. Likely to deploy or PCS in the next 12 months? ☐Deploy ☐PCS Date (if known):

k. Unit:

l. Enterprise (Outlook) email address:	m. Personal email address:

n. Unit Address:	o. Home Address:
Street:	Street:
City: State:	City: State:
Zip:	Zip:
Duty Phone: ( ) -	Home/cell phone: ( ) -

p. Special Duty Status (confirm with your unit surgeon before submitting application):

☐Aviation ☐Ranger ☐HALO ☐Airborne
☐Special Operations ☐SCUBA ☐Air Assault ☐Other:

By initialing next to each item below, you acknowledge that you have read and understood the risks involved with refractive eye surgery. Please contact IACH Eye Clinic if you have any further questions or concerns.

1. I understand that refractive eye surgery may not correct my entire refractive error and that I may still need to wear glasses or contact lenses afterward for best correction of my vision. I understand that there is a risk of persistent dryness, glare, halos and/or other vision disturbances following surgery Init:
2. I understand the importance of attending and making all designated appointments. Should I happen to no show two appointments prior to the surgery I may be disqualified for surgery at that time. Init:
3. I understand that if refractive eye surgery is not successful, I may lose my special duty status and/or may not meet vision standards for application into special duty programs, other career fields, or even continued military service. Init:
3. I understand that the following activities are prohibited for 1 month after surgery, as they may have deleterious effects on the outcome (non-exhaustive list): field training, contact sports/combatives, gas chamber, weapon ranges. Init.
5. I understand that during my preoperative evaluation, I may be disqualified as a refractive eye surgery candidate and not treated. The final decision will be made by an optometrist and/or ophthalmologist. Init:
6. I understand that I will not be eligible for reimbursement of expenses incurred by travel to / from the clinic, including but not limited to travel, meals, and lodging. Init:
7. I understand that WRESP is a not a medically necessary surgery and the right to perform the surgery is determined by the Optometrist or Ophthalmologist based on eligibility, time remaining in service / area, and code of conduct. ☐Yes ☐No Init:

Signature of Applicant:	Print (Last name, First name, MI):	Date:

Encl 3

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	OTSG APPROVED *(Date)* *(YYYYMMDD)*
IACH WRESP PATIENT HISTORY QUESTIONAIRE	

OCULAR HISTORY

Do you have, or have you had, any of the following eye conditions?

Amblyopia / lazy eye	YES	NO
Cataracts	YES	NO
Glaucoma	YES	NO
Conjunctivitis (recurrent)	YES	NO
Corneal ulcer	YES	NO
Double vision	YES	NO
Dry eyes	YES	NO
Herpes simplex / zoster	YES	NO
High eye pressure	YES	NO
Keratoconus	YES	NO
Retinal conditions	YES	NO
Trauma / other (please list below)	YES	NO

_____

MEDICAL HISTORY

Do you have, or have you had, any of the following health conditions?

Arthritis	YES	NO
Breathing difficulty	YES	NO
Diabetes	YES	NO
Heart conditions	YES	NO
High blood pressure	YES	NO
Migraine headaches	YES	NO
Pacemaker	YES	NO
Immunosuppression / HIV	YES	NO
Other medical conditions (please list below)	YES	NO

_____

Females:

In the last 6 months, have you been pregnant or breastfeeding? YES NO

Contact Lens wear?_____Last worn?_____

ALLERGIES

Do you have any allergies to medications? YES NO
If so, list medications and reactions:

_____

OCULAR SURGERY

Have you ever had surgery on your eyes? YES NO
If so, specify the type of surgery and eye(s).

_____

MEDICATIONS

Are you taking, or have you taken, any of the following medications? If so, specify the date last taken:

Accutane (isotretinoin)	YES (Date:_____)	NO	Imitrex (sumatriptan)	YES (Date:_____)	NO
Birth control pill	YES (Date:_____)	NO	Immunosuppresant	YES (Date:_____)	NO
Cordarone (amiodarone)	YES (Date:_____)	NO	Steroids	YES (Date:_____)	NO

List any other medications your are currently taking (or write NONE): _____

(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
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

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REPORT TITLE	OTSG APPROVED *(Date)* *(YYYYMMDD)*
COMMANDER'S AUTHORIZATION FOR REFRACTIVE EYE SURGERY	

Irwin Army Community Hospital (IACH) Warrior Refractive Eye Surgery Program
Phone: (785) 240-7926

The following Soldier is interested in refractive eye surgery to reduce his/her need for corrective lenses:

Rank_____Name_____Last Four SSN_____MOS Type _____[ ] Combat Arms
[ ] Non-Combat Arms

1. Soldier's earliest potential deployment date is_____(DD MMM YY, or N/A)

2. Soldier meets the following criteria:
a. At least 18 years old by the date of surgery (exceptions handled on a case by case basis)
b. At least 6 months remaining on active duty from the date of surgery. End of obligated service date:_____(MMM YY or Indefinite)
c. At least 6 months remaining at Fort Riley or the local area of Kansas (in the same or similar unit) from the date of surgery
d. No adverse personnel actions (e.g., FLAG, UCMJ) pending
e. No Medical Evaluation Board pending

3. After refractive surgery, the Soldier will receive a temporary profile to which the undersigned will adhere:
a. Convalescent leave following surgery: 5 days for LASIK, 7 days for PRK, 10 days for ICL surgery
b. No field training, firing of weapons, driving of military vehicles, sea duty, swimming, or airborne jumps for 1 month
c. No organized PT for 1 month; Soldier may conduct PT at their own pace beginning 2 weeks after surgery
d. No gas chamber or OC spray training for 3 months
e. No wearing of CBRN mask or face paint for 1 month
f. Sunglasses may need to be worn outdoors & in bright lights for a minimum of 3 months
g. No deployments or TDY for at least 1 month after LASIK and ICL; 3 months after PRK

4. Soldier will appear at all follow-up appointments to ensure proper healing at IACH Eye Clinic. Minimum appointments required:
a. PRK: 1 week / 1 month / 3 months
b. LASIK: 1 day / 1 week / 1 month / 3 months
c. ICL: 1 day / 1 week / 1 month / 3 months

5. This authorization is valid for 6 months from the date below.
a. A new authorization must be completed if the Soldier transfers to another unit, another officer assumes command, or if surgery cannot be performed within 6 months of the date below.
b. An Assumption of Command memorandum must accompany this authorization form if it is signed by someone other than the Commander.
c. The undersigned will notify IACH Eye Clinic immediately if the Soldier's circumstances change and they no longer meet the above criteria.

6. By signing below, the Soldier and Commander agree with all the above statements.

Soldier's Signature _____

Commander's Signature _____

Commander's Name (print) _____

Commander's Phone Number _____

Commander's Email address _____

Date of Signature _____

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	*DATE (YYYYMMDD)*
	IACH Eye Clinics	

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name –last, first, middle; grade; date; hospital or medical facility)*

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER *(Specify)*
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT