

Contact Lenses _____
Initials _____
CLINIC USE ONLY

COMMANDER'S AUTHORIZATION FORM
WARFIGHTER REFRACTIVE EYE SURGERY PROGRAM (WRESP)
WBAMC – FT BLISS
(To Be Submitted By ALL Applicants)

1. I give my permission for the following active duty Soldier to be considered for enrollment in the WRESP and for treatment if eligible.

Patient Name (Print) (Last, First MI)	Rank	SSN (Last Four)
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2. I certify the following to be true:
- a. **6 months** remaining in the Active Duty Component (as per OTSG/MEDCOM Policy Memo 18-032)
 - b. No adverse personnel actions pending or medical boards
 - c. Will remain at Fort Bliss for 3 months after surgery.
 - d. Will remain CONUS and is **non-deployable** for 3 months (**90 days**) post-surgery.
3. I realize after refractive surgery the Soldier will be on **convalescent leave for 6 days** and will have a physical profile as follows:
- a. For **one year** sunglasses must be worn outside during daylight hours
 - b. For **one month** may not do the following: No driving a tactical vehicle, no driving of military/government vehicles after sun down, must wear eye pro for 4 weeks while riding in a military vehicle. No swimming, no wearing of pro-mask, no face paint, no organized PT. No contact sports. No combative training. No aerobic activity that generates perspiration as to avoid concentrated sweat entering the eyes. No CBRNE training to include gas chamber or riot control agents. No working in sunny, windy, dusty areas, and non-climate controlled areas. No non-climate controlled living environment. No firing of any weapon system or exposure to live fire, No small pox vaccination.
 - c. **Not to deploy/mobilize 90 days from the date of surgery.**
4. Participation in the WRESP requires some time investment resulting in absence from duty. The soldier **must** keep all scheduled appointments and will receive a No Show if appropriate. **All appointments will be made by the facility and emailed to the soldier 25-30 days in advance.** Typical time requirements are as follows:
- a. Initial eye exam – up to half a day
 - b. Mandatory consent brief – up to half a day
 - c. Surgery – 6 days convalescent leave
 - d. Post-operative exams – 5 visits scheduled during the first year
5. This authorization form is good for 90 days from the date it is signed. If surgery is not completed within that time, a new form will need to be submitted.
6. It is the sole responsibility of the Commander to ensure all requirements are met especially 6 months remaining on active duty.
7. I understand the information above and hereby give my permission/endorsement for this Soldier to be evaluated and considered for enrollment in the Warfighter Eye Surgery Program and to have laser eye surgery if eligible.

 Commanders Name and Rank (**O-2 and below require Assumption Of Command orders**)

 Commanders Signature

WBAMC – Ft. Bliss
 Refractive Eye Surgery Clinic
 (915) 742-7051

 Date

 Phone number

WBAMC - WRESP PATIENT HISTORY QUESTIONNAIRE

Last name		First name		Please answer the following questions carefully and explain any "Yes" answers in the box below.	
Age	Date of Birth	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	OCULAR HISTORY	
Duty Title or Occupation				Do you or have you ever had the following?	
Are you likely to Deploy, PCS, attend School or otherwise leave Ft. Bliss in the next 6 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Eye surgery or laser treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Duty Status		<input type="checkbox"/> Active <input type="checkbox"/> Reserves <input type="checkbox"/> National Guard <input type="checkbox"/> Other <input type="checkbox"/> Active Guard Reserves		Eye injury or trauma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special Duty		<input type="checkbox"/> None <input type="checkbox"/> Ranger <input type="checkbox"/> Airborne <input type="checkbox"/> Air Assault <input type="checkbox"/> HALO <input type="checkbox"/> Aviation/Flight <input type="checkbox"/> SCUBA <input type="checkbox"/> Other <input type="checkbox"/> Special Operations		Told not candidate for Lasik/PRK	<input type="checkbox"/> Yes <input type="checkbox"/> No
List some of your hobbies and activities that require visual needs: (Example: computers, sports, etc.)		1. _____ 2. _____ 3. _____		Dry eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No
What do you hope to achieve from this surgery that will enhance your lifestyle and military job performance? (Example: "Field exercises without glasses getting dirty/broken") (Example: "Play sports without glasses falling off")		1. _____ 2. _____ 3. _____ 4. _____		Recurrent conjunctivitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
ALLERGIES		Are you allergic to any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		Corneal ulcer/infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to any medications? Have you ever had a reaction to: percocet, codeine, or hydrocodone?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No		Corneal scar	<input type="checkbox"/> Yes <input type="checkbox"/> No
MEDICATIONS		Are you taking any of the following medications?		Herpes eye infection	<input type="checkbox"/> Yes <input type="checkbox"/> No
Accutane (isotretinoin)		<input type="checkbox"/> Yes <input type="checkbox"/> No		Keratoconus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Birth control pill		<input type="checkbox"/> Yes <input type="checkbox"/> No		Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cordarone (amiodarone)		<input type="checkbox"/> Yes <input type="checkbox"/> No		Glaucoma or high eye pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
Immunosuppressants		<input type="checkbox"/> Yes <input type="checkbox"/> No		Retina problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Imitrex (sumatriptan)		<input type="checkbox"/> Yes <input type="checkbox"/> No		Poor vision even with glasses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Steroid medication		<input type="checkbox"/> Yes <input type="checkbox"/> No		Thyroid eye disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you currently take any medications?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Iritis/uveitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Ocular rosacea	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Chronic eye pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Glare/halos around lights	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Double vision	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Amblyopia or lazy eye	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Crossed eyes or eye misalignment	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Eye patching or eye exercises	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Problems wearing glasses, contacts	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Reading glasses or glasses with bifocal or prism	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Any chronic eye problems or disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Family history of eye problems (excluding eyeglasses)	<input type="checkbox"/> Yes <input type="checkbox"/> No
				MEDICAL HISTORY	
				Do you or have you ever had the following?	
				Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Breathing problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Pacemaker or heart device	<input type="checkbox"/> Yes <input type="checkbox"/> No
				High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Migraines or chronic headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Immunosuppression/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Lupus or autoimmune disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Fibromyalgia-chronic pain syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Poor wound healing	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Immunizations in past 3 months	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Skin problems: psoriasis or vitiligo	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Any chronic medical conditions (Females) Pregnant or nursing now or in the past 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No

Explain any "Yes" answers from above:

Last Name		First Name		Rank/Grade	Today's Date
SSN	Your Military email address		Civillian email address		Primary phone #
Unit			Duty Phone		MOS
Emergency Contact Person			Phone		Relationship
How many years have you worn glasses?			How old are your current eyeglasses?		
How long have your worn contacts?			Last worn?	Brand	<input type="checkbox"/> Soft <input type="checkbox"/> Rigid

I, _____ (Name) am requesting an evaluation for laser refractive eye surgery at William Beaumont Army Medical Center. By signing below I confirm that I have read and understand the following critical information concerning refractive eye surgery:

1. Certain medical or eye conditions may exist that can disqualify you from having surgery. You may be disqualified or you may withdraw from having surgery at anytime during the pre-operative process. Your doctor will make the final decision on whether you have surgery and what type of surgery (Lasik or PRK).
2. You must not have contact lenses in your eyes for **one month** prior to your pre-operative eye exam and surgery. Not complying may adversely impact the surgical result.
3. You must be available to see us for at least 3 months (but preferably 12 months) of post-operative care (no PCS, deployment, etc in that time frame). You will be required to return for all scheduled post-operative appointments.
4. To be considered for surgery, you must be at least 19 years old, have 6 months before ETS and be Active Duty assigned to an Active Duty unit and not Reserve or National Guard activated or otherwise.
5. You must bring the following to your pre-operative eye exam: current eyeglasses and any available prior eyeglass prescriptions.
6. (Females) You must not be pregnant or nursing 6 months before or after refractive eye surgery as it could adversely impact the surgical result.
7. You must have an escort/driver with you the day of surgery. You will be on con-leave and have a profile after the surgery as outlined on the Commander's Authorization Form.
8. You are not eligible for surgery if you have any adverse actions pending (ie: flag, chapter, medical board, UCMJ, etc).
9. If you are on special duty status now or in the future (ie: flight status, special forces, diver, etc) you must confirm with your unit surgeon that you are eligible for refractive eye surgery and see if any waivers or authorizations are required.
10. The Commander's Authorization Form must be signed and completed before consideration for surgery. The form expires 3 months after signature and if no surgery in that time frame, you will have to be resubmitted.
11. You may still need glasses or contacts after refractive eye surgery for your best vision.

(Signature) _____

(Date) _____