Corneal Collagen Cross-linking Request

Walter Reed National Military Medical Center

- **Please have your Ophthalmologist/Optometrist complete the following pages to be evaluated for a consult for corneal collagen cross-linking (CCXL).**
- **Email completed form to: dha.bethesda.ncr-medical.mbx.laser-vision-center@mail.mil, or deliver to: WRB Refractive Surgery Center, 8901 Rockville Pike, Bldg. 8, Fl. 1, Bethesda, MD, 20889; 0700 - 1530.**

REFERRING PHYSICIAN:

Thank you for referring your patient to us for a CCXL evaluation. Please answer the following questions about the patient. Complete as much as clinically possible to enable us to define progression or stability.

Has the patient been diagnosed with:	Keratoconus	**OD**	**OS**	**OU**
	Post Refractive Ectasia	**OD**	**OS**	**OU**
	- Post LASIK	**OD**	**OS**	**OU**
	- Post PRK	**OD**	**OS**	**OU**

Has the patient had an episode of HSV keratitis in the past?	**YES**		**NO**
Does the patient have a central corneal thickness of at least 400 microns?	**YES**	**NO**	**Unsure**
Has the patient had a topography or Pentacam? *(Please attach **ALL** topographies the patient has had over the years not in AHLTA)*	**YES**		**NO**
Does the patient have any retinal findings noted in their recent dilated fundus exam? List retinal findings: _____	**YES**		**NO**
In your opinion, does the patient show "progression"? (increase in Ks, loss of BSCVA, thinning of cornea, or topographic changes)	**YES**	**NO**	**Unsure**
Has the patient had a gas permeable contact lens over-refraction to determine BCVA OD/OS? BCVA w/gas permeable lens OD_____ *must be done prior to CCXL evaluation BCVA w/gas permeable lens OS _____ *must be done prior to CCXL evaluation	**YES**		**NO**
Does the patient have glasses that are functional to wear during the pre-operative and post-operative periods when contact lens use is not advisable? *If no, please consider prescribing glasses or discuss with the patient how he/she will visually function for the period of time he/she will not be able to wear a contact lens.*	**YES**		**NO**
Will you be providing contact lens care after the procedure, if needed? *If no, you will need to refer the patient to a contact lens provider. Unfortunately at this time, we are unable to provide contact lens care for patients that are not already established at our facility.*	**YES**		**NO**
Is the patient deploying in the next 6 months? *We recommend not deploying until at least 90 days post procedure. Please follow service guidelines regarding visual acuity and deployment.*	**YES**		**NO**

Please call us at **(301) 295-1133** to discuss any questions or concerns regarding patient eligibility for CCXL.

HEALTH RECORD | CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

_____/_____/_____
Month Day Year

CCXL APPLICATION

Complete all testing that is available at your facility.

Patient Name: _____ **Rank:** _____ **SS4:** _____
Last Name, First Name

Branch of Service: _____ **Unit:** _____ **MOS:** _____ **Occupation:** _____

DOB: _____/_____/_____ **Age:** _____ **Sex: M / F** **Females, are you pregnant or nursing? Yes / No**
Month Day Year

Phone Numbers: **Home/Cell:** _____ **Work/Cell:** _____**FAX:** _____

Mailing Address: _____

Email Address: _____ **Duty Station:** _____

ALLERGY: **OD** **Dominant Eye: OD / OS** **OS** **Tech:**

UCVA: 20/_____ J _____

LENSOMETRY: _____ **X _____ 20/**

AUTO-REFRACTION: _____ **X _____**

MANIFEST: _____X _____ 20/

Date: _____

PENTACAM Ks: Flat K: _____ @ _____

Steep K: _____ Kmax _____

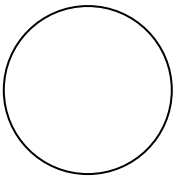
PACHYMETRY: Thinnest_____ Central _____

CL OVER REFRACTION_____ _____ 20/____

TONOMETRY: _____ @_____ Appl/Tonopen

SLE: CHECK IF NORMAL: **ABNORMAL (specify):**

- ☐ **lids/lashes**
- ☐ **conjunctiva**
- ☐ **cornea**
- ☐ **AC / iris**
- ☐ **lens**
- ☐ **central corneal scarring**



UCVA: 20/_____ J _____

LENSOMETRY: _____X _____ **20/**

AUTO-REFRACTION: _____ X _____

MANIFEST: _____X_____20/

Date: _____

PENTACAM Ks: Flat K: _____ @ _____

Steep K: _____ Kmax _____

PACHYMETRY: Thinnest_____ Central _____

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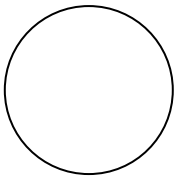
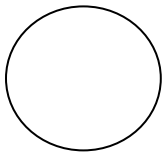


Dilate: M1% N2.5% @ _____

DFE: CHECK IF NORMAL: **ABNORMAL (specify):**

- ☐ **disc (C/D :_____)**
- ☐ **macula**
- ☐ **vessels**
- ☐ **background/periphery**



Dilate: M1% N2.5% @ _____

DFE: CHECK IF NORMAL: **ABNORMAL (specify):**

- ☐ **disc (C/D:_____)**
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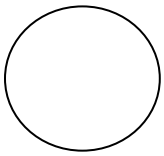

PHYSICIAN SIGNATURE_____