Walter Reed National Military Medical Center

REFRACTIVE SURGERY PRK/LASIK AGREEMENT

Complete Form and Bring to Pre-op

Name/Rank: _____

DOD ID#: _____

EAOS / ETS: _____

Surgery Date: _____

Recommended Convalescent Leave: **7** days beginning on date of surgery, more if indicated by the doctor.

Please sign the following statements indicating agreement:

_____ **I understand that the typical non-deployable period is 3 months after PRK, 1 month after LASIK or ICL.**

_____ **I agree to follow through with the 6 post-operative appointments: Immediate Post-op: 1-day, 4-day; Subsequent Follow-up: 1-month, 3-month, 6-month and 12 months.**

_____ **I understand that my Immediate Post-op will be done at the surgery center, which may extend beyond the 4-day post-op if my eye(s) is not healed.**

_____ **I understand that I may be required to be seen on a daily basis, past the recommended convalescent leave, if medically necessary.**

_____ **I understand that all costs of travel, meals, lodging, and associated expenses will be borne by me or my command.**

_____ **I understand that although I will be returning to my post after the convalescent leave expires, my vision in the next few weeks may limit what I am able to perform.**

_____ **I am currently on regular active duty status and will be so for at least the next 6-12 months after refractive surgery; I am an activated reservist or a training reservist.**

_____ **I have read and understand the contents of the instruction letter sent to me by email.**

Service Member's Signature:_____ Date:_____

Signed by 1st officer of chain with title or Commanding Officer of the unit for approval/disapproval:

◉ **Approved** ○ **Disapproved:_____ Date:_____**

FOLLOW UP CARE

Please have your local optometrist or ophthalmologist who will be providing your Subsequent Follow-up care when you return to your duty station sign the following statement, **OTHERWISE YOU ARE REQUIRED TO COME BACK TO WRNMMC FOR ALL FOLLOW UP CARE**.

I understand that the service member named above is scheduled to have PRK/LASIK on _____. I accept responsibility for providing Subsequent Follow-up care as listed above for this patient in accordance with standards of care. ***I agree to fax a copy of all patient post-operative exams to Refractive Surgery - WRNMMC at (301) 295-4751 if not entered in AHLTA (military e-record).***

_____

Eye care provider - printed name/phone number/location

Eye care provider signature

WRNMMC Opthalmology LVC Clinic (301) 295-1133