

INSTRUCTIONS FOR COMPLETING THE PACKET

1. Read over all of the information on each page carefully.
2. Initial at the bottom of each page.
3. On page 2, Myopia (Nearsighted) and Hyperopia (Farsighted).
4. On page 6, you must fill in the statements and have someone witness you signing your packet.
5. Patient Identification Box on every page must include Last Name, First Name, Last 4 of your SSN, Date of Birth and Unit.

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

INFORMED CONSENT FOR LASER REFRACTIVE SURGERY

OTSG APPROVED (Date)

(YYYYMMDD) 20090202

PATIENT NAME: _____

Your doctor has determined that you are a good candidate for laser refractive surgery for the correction of your refractive error (nearsightedness, farsightedness, and/or astigmatism). There are two forms of laser refractive surgery currently available: photorefractive keratectomy (PRK) and laser-assisted in situ keratomileusis (LASIK). Both procedures use the excimer laser to reshape the front surface of the eye (cornea) and both procedures are permanent and irreversible.

The excimer laser is an FDA approved medical device that uses ultraviolet light energy to reshape the cornea so that visible light entering the eye is focused properly, resulting in a possible reduction or correction of myopia, farsightedness, and/or astigmatism.

Photorefractive keratectomy (PRK): After removing the outermost layer of the cornea (the epithelium) PRK uses the excimer laser to reshape the underlying cornea. A soft contact lens is then usually placed over the treated cornea while the corneal epithelium is healing.

Laser-assisted in situ keratomileusis (LASIK) A keratome (a surgical instrument much like a carpenter's plane) first creates a disc or flap of corneal tissue. This flap is then folded back in such a way that the excimer laser can be used to remove microscopic layers of tissue from the underlying cornea. Once the laser treatment is completed, the flap is then returned to its original position.

PRK and LASIK surgery are performed under a topical anesthetic to numb the eye and make it so there is minimal discomfort during the procedure.

You are entitled to be informed about the proposed LASIK/PRK treatment for MYOPIA (NEARSIGHTEDNESS), with or without astigmatism, HYPEROPIA (FARSIGHTEDNESS), with or without astigmatism, including the risks of the treatment and the alternatives. This information is provided so that you can make an informed decision regarding laser refractive surgery. Please read this document thoroughly and discuss the content with your doctor, so that all of your questions are answered to your satisfaction.

Patient's Initials _____ Page 1 of 6

(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
- OTHER EXAMINATION OR EVALUATION
- DIAGNOSTIC STUDIES
- TREATMENT

- FLOW CHART
- OTHER (Specify)

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REPORT TITLE

PATIENT STATEMENT

OTSG APPROVED (Date)
(YYYYMMDD) 20090202

I have MYOPIA with or without astigmatism, which requires me to wear corrective lenses in order to see clearly for my daily activities. I have been informed of the alternatives including eyeglasses, contact lenses, and other types of refractive surgery.

I have HYPEROPIA with or without astigmatism, which requires me to wear corrective lenses in order to see clearly for my daily activities. I have been informed of the alternatives including eyeglasses, contact lenses, and other types of refractive surgery. I acknowledge that I understand the following information:

POTENTIAL BENEFITS: The goal of LASIK or PRK is to reduce or eliminate myopia with or without astigmatism or hyperopia with or without astigmatism. The potential benefit of the procedure is to reduce my need for corrective lenses and improve my vision without glasses or contact lenses.

ALTERNATIVES: The alternate procedure(s) of course of treatment has been explained to me as follows: I can continue to wear either glasses or contact lenses to correct my refractive error. Surgical alternatives include PRK or LASIK.

RISKS: I understand that with all forms of treatment, the results of my surgery cannot be guaranteed. This is also NO GUARANTEE that I will eliminate my reliance on glasses or contact lenses. It is possible that the treatment could result in under correction, where I may have some residual myopia or hyperopia. It is also possible the treatment could result in overcorrection, which may or may not require the use of glasses or contact lenses. It is possible that this treatment may increase my dependence on reading glasses or that I may require reading glasses at an earlier age. The treatment could also result in a change in my astigmatism that could cause the need for the use of glasses or contacts lenses. I understand that further treatment may be necessary, including the use of eye drops, the wearing of glasses or contact lenses, and/or additional treatment with the laser.

I have been informed that complications can occur after the procedure including:

Decrease in best-corrected visual acuity. A decrease in my best possible vision with eyeglasses or contact lenses may occur, usually transiently. However, I may not be able to read the last 2 lines or more of the eye chart regardless of corrective lens assistance.

Patient's Initials____ Page 2 of 6

(Continue on reverse)

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OTHER EXAMINATION OR EVALUATION

OTHER (Specify)

DIAGNOSTIC STUDIES

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Glare and halo. I may experience glare from bright lights or halos around lights, especially at night. The glare may be severe enough to cause difficulty driving at night (up to 3%). This may occur immediately after the procedure and usually resolves spontaneously. However, I understand that highly myopic patients are at greater risks of experiencing haze, and patients with large pupils may be at an increased risk report night glare.

Decrease in contrast sensitivity. A decrease in the quality of vision may occur even with excellent visual acuity. This may occur immediately after the procedure and usually resolves spontaneously.

Corneal scarring. A scar dense enough to affect vision may occur after the procedure (up to 2%). The scar may respond to treatment.

Elevated intraocular pressure. High pressure in my eye may reduce vision. This may occur while taking eye drops after the procedure and usually responds to treatment.

Other complications which have been reported in less than 1% of treated eyes included: cataract, ulceration, infection, inflammation of the iris double vision, drooping of the eyelid, and corneal inflammation. Since its impossible to state every complication of laser refractive surgery, it is understood that the above list of complications is not complete or exhaustive. Fortunately, most complications are rare, temporary, or mild. I understand that the long-term effects associated with LASIK or PRK procedures are not fully known.

There is a small risk during the LASIK of experiencing a corneal flap complication. A corneal flap that is too thin may result in postponement of the procedure; prolong visual recovery, and/or temporary or permanent blurred vision. Other potential corneal flap complications included corneal flap incision that is too long, resulting in a free flap; this may increase the potential for prolonged visual recovery, blurred vision, and epithelial growth. Corneal flaps that are too short necessitate postponing the procedure. The most potentially serious risk is a corneal flap that is too deep, which results in perforation of the eye, but this is very rare.

During the first several hours after LASIK procedure, the epithelial protective layers grow over the corneal flap. There is potential for developing epithelial cell growth under the flap, which may necessitate lifting the flap and removing the ingrowth. This occurs rarely.

There is a risk of inducing astigmatism or of astigmatism appearing in another party of the cornea.

Risks of bilateral surgery. By having treatment of both eyes at the same time, I recognize that I could have one or more of these problems in both eyes at the same time.

Blurring is very common in the healing process. It takes generally 3 to 10 days to clear. However, I recognize that it may take longer. My visual acuity will generally be stabile in about 3 weeks, although full recovery, especially PRK, may take 4 to 6 months or even longer.

I understand that if I needed reading glasses prior to treatment, I will most likely need reading glasses after the treatment. I also understand that if I currently don not need reading glasses, I may need them at sometime after the procedure.

Patient's Initials _____ Page 3 of 6

(Continue on reverse)

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OTSG APPROVED (Date)
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I understand that if my eyes were dry before surgery that they will most likely still be dry after the surgery. Temporarily, my eyes may be drier than before the surgery. Artificial tear drops may be needed after surgery.

I understand that if I'm having LASIK after I've had a previous surgery such as a prior LASIK, radialkeratotomy, intracorneal rig segments, corneal transplant, or other types of eye surgery, that the incisions for these surgeries may not hold up to the LASIK surgery. This may require additional surgery to close these incisions.

FEMALES: I am not pregnant or nursing. If it is possible that I am pregnant, then I will obtain a pregnancy test to ascertain that I am not pregnant, since pregnancy could adversely affect the treatment result. Also, I will notify my eye doctor immediately if I become pregnant with the 6 months following treatment.

I understand the treatment should not be performed on persons with uncontrolled vascular disease or autoimmune system disease, or on patients who are immunocompromised or on drugs or therapy which suppress the immune system, so I will tell the doctor if I have any of these or other medical conditions.

I understand the treatment should not be performed on persons with signs of keratoconus (a corneal condition) since eyes with this condition may have unstable corneas.

I understand the treatment should not be performed, or performed with caution on persons known to have a history of keloid formation.

I understand the use of a bandage soft contact lens immediately after the PRK procedure has not specifically approved by the FDA. The contact lens is used to reduce postoperative pain or discomfort which can be severed without the lens. The contact lens however, can increase the risk of corneal infection or inflammation (1-2%). I will inform my doctor if I do not want a contact lens used after the procedure.

I give permission for the medical data concerning my operation and any subsequent treatment to be submitted for outcome data analysis. I understand that my identity will be kept strictly confidential in any reports or journal articles.

I understand that LASIK or PRK treatment requires follow-up care at prescribed intervals for one year after treatment, and I agree to return for required examinations as requested.

Although it is impossible for the doctor to inform me of every conceivable complication that may occur, I acknowledge that the doctor has answered all of my questions to my satisfaction. I understand that if I have any questions with respect to the treatment, I can call my physician.

Patient's Initials _____ Page 4 of 6

(Continue on reverse)

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INFORMED CONSENT FOR LASER REFRACTIVE SURGERY

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SPECIAL MILITARY CONSIDERATIONS: I understand that LASIK is disqualifying for attending any USASOC sponsored schools such as HALO, SCUBA, Special Forces Qualification course, SERE, and certain ARSOF. PRK is allowed for Special Operations personnel. Soldiers who have any interest in serving in Special Operations should NOT undergo LASIK treatment for any reason. I also understand that personnel on flight status or receiving flight pay are not allowed to have any refractive surgery, and may lose their flight status and flight pay if they undergo refractive surgery. Radial Keratotomy, an alternative to LASIK, is not allowed for any active duty personnel.

If my vision after surgery should fall outside the minimum acceptable for my job, I understand that I may be required to change my rate/designation. I also understand that the surgery may disqualify me from commissioning or certain occupations such as aviation.

If I suffer any injury directly related to my surgery, immediate medical attention is available at the nearest military medical treatment facility, if applicable. I understand that although no financial compensations is available, any injury resulting from my surgery will be evaluated and treated in keeping with the benefits of care to which I am entitle under applicable Army, other Department of Defense, and other state or federal regulations.

Patient's Initials _____ Page 5 of 6

(Continue on reverse)

PREPARED BY (Signature & Title)

DEPARTMENT/SERVICE/CLINIC

DATE (YYYYMMDD)

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- HISTORY/PHYSICAL
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- OTHER (Specify)

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REPORT TITLE

PATIENT AGREEMENT

OTSG APPROVED (Date)
 (YYYYMMDD) 20090202

MY SIGNATURE INDICATES THAT I HAVE READ AND UNDERSTAND THE INFORMATION COVERED IN THIS CONSENT AND PROVIDED BY MY DOCTOR OR HIS/HER STAFF. I HAVE FULLY DISCUSSED THE RISKS, BENEFITS, AND ALTERNATIVES WITH MY PHYSICIAN. I HAVE HAD AN OPPORTUNITY TO ASK MY PHYSICIAN QUESTIONS AND WOULD LIKE TO PROCEED WITH THE TREATMENT.

Please write in the box below: "I may not achieve the result I hope for."

Please write in the box below: "There are risks and there are no guarantees."

I UNDERSTAND THAT THIS TREATMENT IS AN ELECTIVE PROCEDURE AND THAT I DO NOT HAVE TO HAVE THIS TREATMENT. I UNDERSTAND THAT LASIK OR PRK TREATMENT MAY NOT BE REVERSIBLE. MY DECISION TO UNDERGO LASER ASSISTED IN SITU KERATOMILEUSIS (LASIK) OR PHOTOREFRACTIVE KERATECTOMY (PRK) HAS BEEN MY OWN AND HAS BEEN MADE WITHOUT DURESS OF ANY KIND.

I HAVE ELECTED TO UNDERGO AND GIVE PERMISSION FOR: LASIK PRK

EYES TO BE TREATED: Both Eyes Right Eye Left Eye

Date: _____

 Patient (Please Print)

 Patient Signature

 Witness (Please Print)

 Witness Signature

 Physician (Please Print or Stamp)

 Physician Signature

Patient's Initials _____ Page 6 of 6

(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)

- | | |
|--|--|
| <input type="checkbox"/> HISTORY/PHYSICAL | <input type="checkbox"/> FLOW CHART |
| <input type="checkbox"/> OTHER EXAMINATION OR EVALUATION | <input type="checkbox"/> OTHER (Specify) |
| <input type="checkbox"/> DIAGNOSTIC STUDIES | |
| <input type="checkbox"/> TREATMENT | |

Commander's Authorization
Irwin Army Community Hospital, Ft Riley, Kansas 66442
Warfighter Refractive Eye Surgery Program (WRESP)

1. I hereby give my permission for the following Soldier to be evaluated and considered for enrollment in the WRESP and for their PRK eye surgery if eligible.

Name: _____ Rank: _____ MOS: _____

SSN: _____ ETS DATE: _____ UNIT: _____

Contact Phone Number: _____ / _____ EMAIL: _____

Likely to travel for the following reasons in the next 4 Months? (Please Circle)

PCS TDY SCHOOL NTC DEPLOY LEAVE Projected Date _____

Is service member projected to deploy? _____ When? 3 mth 6 mth 12 mth 18 mth

Did service member recently deploy? _____ When? _____

2. I certify that the following are true and will inform IACH Eye Clinic if SM circumstances change:

- a. Soldier has 12 months remaining on active duty.
- b. Soldier has no adverse personnel actions pending.
- c. Soldier will remain CONUS for at least 90 days after surgery.
- d. Soldier has at least 90 days prior to attending JRTC/NTC.

3. I realize that after surgery, SM will have 7 days convalescent leave. In addition, I understand that the SM will have the following profile for a minimum of 21 days:

- a. No field duty or driving military vehicles.
- b. No organized PT-May do modified individual PT indoors.
- c. No swimming, protective mask use, or use of camouflage paint.
- d. May wear sunglasses at all times.

4. I further realize that participation in this program requires a considerable investment of time resulting in absences from duty and will ensure that the soldier will keep all appointments. Minimum requirements are as follows:

- a. Initial exam (IACH)-up to half a day.
- b. Surgery-seven days convalescent leave.
- c. Postoperative evaluations at IACH-5 day, 6 week, and any further follow ups as needed.

Commanders Signature

Commander's Name and Rank

Date Phone Number

Patient Identification

Name (Last, First) _____ Rank _____

Unit _____ SSN _____

IRWIN ARMY COMMUNITY HOSPITAL
REFRACTIVE EYE SURGERY PROGRAM

PRK Pre-Operative (Before Surgery) Instructions

Day of Surgery:

1. DO NOT arrive on an empty stomach.
2. Do wear comfortable clothing.
3. Bring a driver other than yourself.
4. Bring sunglasses and bring ID card.
5. Bring prescription glasses for non-operative eye (if applicable).
6. Report to Ophthalmology on the 5th Floor of the hospital.
7. Call if you are ill prior to surgery to see if we need to reschedule surgery (785) 240-7335.
8. **DO NOT** wear the following:
 - a. Earrings or Necklaces.
 - b. Make-up (especially eye make-up).
 - c. Creams or lotions on face.
 - d. Contact Lens (for 4 weeks prior to surgery).
 - e. Perfume, cologne and aftershave.
 - f. Hair spray or other sprays, mists, etc.
 - g. **DO NOT** smoke that morning.

What to expect the day of your surgery:

1. Valium (diazepam) one 5 mg tablet. Should be taken by mouth 45 minutes prior to surgery. **Do not drive.**
2. While you wait your paperwork will be reviewed.
3. You will be brought to the laser treatment room and seated.
4. A patch is placed over the non-operative eye to allow you to better concentrate on the blinking red light during the procedure.
5. Anesthetic eye drops are placed on the operative eye.
6. The chair is moved into position bringing the operative eye under the laser.
7. An eyelid speculum is placed into the operative eye to keep the eyelids open.
8. You will see a series of lights including a blinking red light in the center of the others.
9. You will be asked to **focus on the blinking red light** and the procedure will begin.
10. The surgery is painless.
11. Your vision will become blurry during the surgery. This normal and expected.
12. The popping noise you hear next to your right ear is the laser at work. Focus on the blinking red light.
13. At the end of the surgery, several drops are placed on the eye to help prevent pain, inflammation and infection and a bandage contact lens is then placed on the eye.
14. The procedure will be repeated on your other eye, if applicable.
15. Expect your vision to fluctuate and be blurry for days to weeks to months after surgery.
16. Pos-op (after surgery) instructions are on another paper.

If you have any questions concerning your surgery place call Ophthalmology Clinic at (785) 240-7335.

IRWIN ARMY COMMUNITY HOSPITAL
REFRACTIVE EYE SURGERY PROGRAM

PRK Post Operative (After Surgery) Instructions

General Guidelines:

1. Wear your sunglasses whenever you are outside during daylight hours for comfort and for optimal long term results.
2. Do not rub your operative eye.
3. Do not remove the contact lens. The doctor will remove it at the appropriate time.
4. If the contact lens falls out, leave it out. Do not attempt to reinsert it. Pain may or may not increase.
 - a. Continue to use your medication as directed.
 - b. Call the clinic during duty hours for further instructions.
 - c. Report to IACH ER if after duty hours.
5. No strenuous physical activity for the first week following surgery.
6. Do not swim for two weeks following surgery.
7. It is ok to shower or bathe but avoid getting water directly into the operative eye(s).
8. Try to stay away from smoke or dusty rooms or areas with chemical vapors.
9. Do not drive or operate machinery or appliances while taking narcotic pain medication.
10. Some of your eye drops may sting or cause temporary blurred vision.
11. Maintain your usual diet and medications.
12. Drink plenty of water.
13. Use the medications prescribed by your physician as prescribed. (See Medication Instructions Sheet).
14. Expect fluctuating, blurry vision for days, to weeks, to months, after surgery.
15. No deployments while on steroid drops (profile).

How to use your eye drops:

1. Wash your hands first.
2. Do not touch the dropper to skin, eyelashes or the eye (i.e. keep them sterile).
3. Shake the bottles well before use.
4. Tilt your head back, look upwards and pull down the lower eyelid.
5. Place the dropper directly over the eye and administer one drop.
6. Gently close your eye for 1-2 minutes.
7. Do not blink during this time interval. This allows the medication to enter the eye tissues.
8. Do not rinse dropper or otherwise try to "clean" it.

Report any of the following to your eye doctor:

1. Contact lens comes out.
2. Excessive pain or pain not relieved by pain medications.
3. Nausea or vomiting.
4. Development of a rash or itching.

Medications:

1. VIGAMOX (tan top)- 1 drop in both eyes 4 times a day.
2. FML (white top)- 1 drop in both eyes 4 times a day.
3. REFRESH PLUS (box)- 1 drop in both eyes every 1-2 hours as needed for irritation.
4. VICODIN(tablets)- 1-2 tablets every 6 hours as needed for pain.

Follow-up appointment. The appointment will be given to you after the procedure is completed. It is written on your medication bag.

Clinic Number: (785) 240-7335