

WRAMC Warfighter Refractive Eye Surgery Program Managed Care Agreement

(FOR POST-OPERATIVE CARE AT A FACILITY OTHER THAN WALTER REED)

Patient Name (Print) Rank SSN

Military Installation Phone E-mail

In the next 6 months are you: _____
Deploying (Yes/No) If Yes when? (ddmmmyyyy) PSC'ing (Yes/ No) If Yes when? (ddmmmyyyy)

Patient Agreement (initial each statement)

_____ I request to be returned to my Optometry Clinic at _____
for post-operative care following refractive surgery at Walter Reed Army Medical Center. The Refractive Surgery
Center staff will be available for additional consultation as needed.

_____ I will contact this Optometry Clinic to schedule my first follow-up appointment as soon as I am notified of my
surgery date.

_____ I understand that post-operative follow-up appointments are required at 1-week, 1-, 3-, 6- and 12-months.
If I am deploying before the 6-month exam is due I will complete the 1-week, 1- and 3-month exams and then return
to this Optometry Clinic for a post-operative exam at the completion of my deployment.

Patient Signature Date

Co-Managing Provider's Agreement (initial each statement)

_____ I agree that I will manage this patient and accept responsibility for his/her post-operative care. Post-operative
appointments will be scheduled at 1-week, 1-,3-,6- and 12-months. If the soldier is deploying before the 6-month
exam is due then they will complete the 1- and 3-month exams and then return for a post-operative exam at the
completion of their deployment.

_____ I will email or fax the results of each follow-up exam to the Center for Refractive Surgery at WRAMC.

Optometrist Stamp/Signature Optometrist's Name (Print) Rank Date

Military Installation Phone Fax Email

**FAX THIS COMPLETED FORM TO THE CENTER FOR REFRACTIVE SURGERY AT 202-782-4653
KEEP A COPY FOR YOUR RECORDS AND BRING IT TO YOUR FIRST APPOINTMENT**