

WRAMC Warfighter Refractive Eye Surgery Program Referral Form

(TO BE SUBMITTED BY ALL APPLICANTS)

Patient Name (Print) Rank SSN

Email Address (AKO Preferred)

Contact Lens History

To be completed by the **APPLICANT**

CONTACT LENS WEARERS Please read and initial the appropriate requirement:

_____ I wear **SOFT CONTACT LENSES** and will be out of them for at least **TWO WEEKS** before all appointments.

_____ I **SLEEP** in my **SOFT** lenses or wear **GAS PERMEABLE** or **TORIC** soft contact lenses and will be out of them for at least **THREE WEEKS** before any appointment.

To be completed by the **EXAMINING PROVIDER**

EXCLUDE patients who answer **YES** to any of the following:

- Refraction has **CHANGED** more than **0.50 DIOPTERS** in one year? YES / NO
- Has taken **IMMETREX** or **STEROIDS** within the past **YEAR**? YES / NO
- Has a history of **KERATOCONUS**? YES / NO
- Is **PREGNANT**, **PLANNING** to become pregnant or **NURSING**? YES / NO
- Has had a **SMALLPOX** vaccination within the **PAST THREE MONTHS**? YES (Date _____) / NO

Note that ALL the following MUST be completed for a valid application. If the applicant has had a manifest refraction within the past year the data can be recorded without the need for a repeat refraction.

	OD	OS
Current Glasses Rx	_____ x _____	_____ x _____
Date of Rx	_____	
Manifest Refraction	_____ x _____	_____ x _____
Best Corrected VA	20/ _____	20/ _____
Cycloplegic Refraction (must be performed on all hyperopes under age 40)	_____ x _____	_____ x _____

Date: _____ Examining Provider: _____

**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**