

60th MDG Dependent and Retiree Refractive Eye Surgery Program (DRRESP) Center Application Guide

David Grant Medical Center, 60th Medical Group, DRRESP Center | Travis AFB, CA 94533 Contact: (707) 423-3146



Application Instructions and Guidance:

1. It is **highly encouraged** to **digitally complete** all required forms. Moreover, **do not leave any sections blank**.
2. Note that **Photorefractive Keratectomy (PRK)** is the only procedure offered at this time. You must be at least 18 years of age, your sponsor must be stationed at Travis AFB for at least 12 months from the date of surgery, and your **Primary Care Manager (PCM)** must be at David Grant Medical Center. Retirees must also reside locally to the Travis AFB area.
3. **Discontinue contact lens use** before the first appointment: **30 days for soft lenses and 90 days for hard lenses**.
4. **Complete all components** listed in Section 1 of the **60th MDG Dependent and Retiree Request for Refractive Surgery Consultation**.
5. Review the **Patient Acknowledgment and Agreement** section and **sign** where applicable.
6. Schedule an **exam** with your local **optometry clinic** to complete Section 2. Civilian referrals are acceptable (i.e., Vista Optical at the BX Mini Mall or your civilian optometrist). This exam is required to obtain a **referral** to ophthalmology for refractive surgery. **Referring providers from civilian/private practices must include a ICD-10 diagnostic code on the referral for our Referral Management Center**. Applicants must also demonstrate stability in their glasses prescription (manifest refraction) for at least one year. If your eye care is from a civilian/private practice, include two eye exams with manifest refractions spaced at least 12 months apart with your application.
7. After receiving the referral, activate it through the **Patient Services Center (DGMC, 2nd floor, near radiology and the lab, phone: 707-423-7923)**. **If not seen by a DGMC optometrist**, activation can be accomplished by **delivering the referral in person or by faxing it to 707-423-7535**.
8. Once Section 2 is complete and the referral is activated, complete the **Patient Information and Medical History Form** and email the complete application to the DRRESP Center with the subject "**Dependent and Retiree Application for Refractive Surgery**" using secure messaging through the **MHS GENESIS Patient Portal**. On the home page select "**Messages**" within the top section and click the button that says "**Send a message**." In the "**To**" line type "**Travis Ophthalmology Refractive Clinic**". Attach your completed application, enter a message, and click "**Send**." **Alternatively**, you may drop-off your application at the Ophthalmology Department.
9. The DRRESP Center will respond to the **application within 30 days**. If no response is received, follow up via email or phone. It is the applicant's responsibility to keep their contact information up to date.
10. After reviewing the application, the DRRESP Center will determine eligibility for a refractive surgery consultation. Applicants who **meet the criteria may be offered refractive surgery consultation**.
11. If approved, you will be **contacted to schedule a consultation appointment**.
12. Once qualified and scheduled for surgery, you must **pay for the procedure (Debit/Credit only)**, prior to attending the consent briefing, at the **Cashier Cage/MSA Office in room 2A607** at David Grant Medical Center. An invoice will be provided for the applicant to pay for and receive a receipt. The receipt must be presented to the surgery center to proceed.

Instructions for Referring Providers

1. To be considered for the Dependent and Retiree Refractive Eye Surgery Program (DRRESP), the applicant must complete a screening exam with an optometrist or ophthalmologist.
2. The referring provider must complete Section 2: "Referring Optometrist/Ophthalmologist Recommendation." Any abnormalities in the exam must be documented in the comments section.

60th MEDICAL GROUP DEPENDENT AND RETIREE REQUEST FOR REFRACTIVE SURGERY CONSULTATION

Privacy Act Statement

AUTHORITIES: Public Law 117-81, National Defense Authorization Act for Fiscal Year 2022, Section 732, Treatment of Anomalous Health Conditions; 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C., Chapter 55, Medical and Dental Care; Department of Defense (DoD) Instruction 6015.23, Foreign Military Personnel Care and Uniform Business Offices in Military Treatment Facilities (MTFS); DoD Manual (DoDM) 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs;" and E.O. 9397 (SSN), as amended.

PURPOSE: This form collects info from dependents and retirees applying for refractive surgery. Applicants must submit the completed form via email to a Dependent Refractive Eye Surgery Program (DRESP) Center. The info will be used to determine eligibility for an in-person surgery evaluation at the DRESP Center.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. § 552a(b) of the Privacy Act of 1974, as amended, these records may specifically be disclosed outside the DoD as a routine use to private physicians and federal agencies (including the Departments of Veterans Affairs, Health and Human Services, and Homeland Security for members of the Coast Guard) in connection with your medical care, government agencies to determine your eligibility for benefits and entitlements, government and non-government third parties to recover the cost of Military Health System (MHS) provided care, public health authorities to document and review occupational and environmental exposure data, and government and non-government organizations to perform DoD-approved research. For a complete listing of the routine uses, see the below hyperlinked SORN.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

APPLICABLE SORN: EDHA 07, Military Health Information System (June 15, 2020; 85 FR 36190)
<https://dpcl.d.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf>

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but the MHS may be unable to provide you with comprehensive healthcare.

SECTION 1: Applicant Information (To be completed by the applicant)

LAST NAME:	FIRST NAME:	
DOB (YYYYMMDD):	AGE:	DOD ID:
WORK TELEPHONE:	MOBILE TELEPHONE:	
HOME EMAIL:	WORK EMAIL:	
Is your Primary Care Manager located at David Grant Medical Center?	YES	NO

Sponsor Information (To be completed by the applicant's sponsor)

LAST NAME:	FIRST NAME:	
RANK:	DOD ID:	
WORK TELEPHONE:	MOBILE TELEPHONE:	
CURRENT DUTY STATION:	SQUADRON:	
PROJECTED CHANGE OF STATION DATE (YYYYMMDD)	<i>Sponsor cannot PCS within 12 months.</i>	
CURRENT END OF ACTIVE DUTY COMMITMENT DATE (YYYYMMDD):		
MILITARY BRANCH:		
SERVICE TYPE:		

PATIENT ACKNOWLEDGEMENT AND AGREEMENT

1. I understand that refractive surgery is an elective and irreversible procedure, and perfect vision is not guaranteed.
2. My sponsor will not PCS (Permanent Change of Station) within 12 months of my scheduled surgery.
3. I am aware that I may not be able to obtain post-operative care at another facility if I relocate.
4. I understand that enhancement surgery may be considered on a case-by-case basis within 12 months after the initial procedure.
5. I agree to follow through with all post-operative appointments, including: 1-week, 1-month, 3-month, 6-month, and 12-month follow-ups.
6. I understand that I may be required to be seen on a daily basis beyond the recommended convalescent leave, if medically necessary.
7. I understand that all costs associated with travel, meals, lodging, and other related expenses are my personal responsibility.
8. I acknowledge that although I may return to work after convalescent leave, my vision may be temporarily limited and affect my work performance.

Have you had refractive surgery before?

Are you pregnant or nursing (currently or in past 6 months)?

Have you or a family member been diagnosed with keratoconus, pellucid, or ectasia?

PATIENT NAME (Last, First):

PATIENT SIGNATURE:

DATE:

SECTION 2: Referring Doctor's Recommendation (To be completed by Optometrist/Ophthalmologist).

PROVIDER'S LAST, FIRST NAME:

SIGNATURE:

CLINIC TEL (include area code):

LOCATION:

DATE OF EYE EXAMINATION (YYYYMMDD):

PROVIDER EMAIL:

MRx Date:					CRx Date (If available):					Contacts	UDVA	Pachymetry
	Sphere	Cylinder	Axis	CDVA		Sphere	Cylinder	Axis	CDVA	Date last worn:	OD: 20/	OD:
OD:				20/	OD:				20/			
OS:				20/	OS:				20/	Type (soft v. hard):	OS: 20/	OS:

MRx Older Than 1 Year Date:

VERIFICATION (each statement must be verified):

≤ 0.50D change in sphere or cylinder in last 12 months

Pentacam or topography attached and uploaded to electronic medical record (If available)

No dry eyes/blepharitis or dry eyes/blepharitis managed

Comments:



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Patient Information & Medical History Form



David Grant Medical Center, 60th Medical Group
DRRESP Center, Travis AFB, CA 94533 Phone: (707) 423-3146

Digitally complete all sections, do not leave any items blank. If a topic does not apply, enter "N/A."

PATIENT INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOD ID
JOB TITLE OR OCCUPATION	DATE OF BIRTH	AGE	SEX
HOME ADDRESS	CITY	STATE	ZIP

OCULAR HISTORY <small>Check Yes/No</small>	MEDICAL HISTORY <small>Check Yes/No</small>
Do you have or have you ever had the following eye conditions?	
Amblyopia/ lazy eye	No <input type="checkbox"/> Yes <input type="checkbox"/>
Cataracts	No <input type="checkbox"/> Yes <input type="checkbox"/>
Conjunctivitis, recurrent	No <input type="checkbox"/> Yes <input type="checkbox"/>
Ocular Rosacea	No <input type="checkbox"/> Yes <input type="checkbox"/>
Double vision	No <input type="checkbox"/> Yes <input type="checkbox"/>
Severe dry eyes	No <input type="checkbox"/> Yes <input type="checkbox"/>
Glaucoma or high eye pressure	No <input type="checkbox"/> Yes <input type="checkbox"/>
Ocular Herpes Simplex / Zoster	No <input type="checkbox"/> Yes <input type="checkbox"/>
Keratoconus	No <input type="checkbox"/> Yes <input type="checkbox"/>
Retinal problems	No <input type="checkbox"/> Yes <input type="checkbox"/>
Trauma	No <input type="checkbox"/> Yes <input type="checkbox"/>
Previous eye surgery or PRK/LASIK eval?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Do you have or have you ever had any of the following?	
	Psoriasis <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Vitiligo <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Rheumatoid arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Ulcerative Colitis or Crohn's disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Thyroid disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Heart disease or pacemaker <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Autoimmune disease <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Migraine headaches <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Fainted/light headed during eye exam <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Pregnant/Nursing in past 6 months <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>
	Planning to become pregnant within 1 year? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/>

Explain any yes or indicate other eye condition not listed: 	Other medical conditions not listed:
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MEDICATIONS HISTORY <small>Check Yes/No</small>	MEDICATION ALLERGIES <small>Do you have any medication allergies?</small>
Are you taking or have you ever taken any of the following?	
Accutane (isotretinoin) Date: <input type="checkbox"/> No <input type="checkbox"/> Yes	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, list drug and reaction:
Immunosuppressants Date: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Steroid medication Date: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Cordarone (amiodarone) <input type="checkbox"/> No <input type="checkbox"/> Yes	
TB meds (INH) within past 30 days <input type="checkbox"/> No <input type="checkbox"/> Yes	REFRACTIVE HISTORY
Smallpox vaccination within past 3 weeks <input type="checkbox"/> No <input type="checkbox"/> Yes	How many years have you worn glasses? <input type="text"/>
List all medications that you are currently taking, including over-the-counter (OTC) and any in the above list. 	Do you wear or have you ever worn bifocals? <input type="text"/>
	How many years have you worn contact lenses? <input type="text"/>
	Soft or hard lenses? <input type="text"/>
	Date you stopped wearing them? (Required) <input type="text"/>
Discontinue use of contact lenses prior to first appointment (soft lenses: minimum 30 days, hard lenses: minimum 90 days).	

ADDITIONAL INFORMATION

What do you hope to achieve from having PRK/LASIK?

COMPLETED BY PATIENT

SIGNATURE	DATE