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.

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. Applicants must demonstrate stability in glasses prescription (manifest refraction) for at least 1 year. This requires at least two manifest refractions that are 12 months apart.

7. After receiving the referral, activate it through the **Patient Services Center (DGMC, 2nd floor, near radiology and the lab). If not seen by a DGMC optometrist,** activation can be accomplished by **delivering in person or by fax at 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 Opthalmology 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://dpcld.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)	***Sponsor cannot PCS within 12 months.***
CURRENT END OF ACTIVE DUTY COMMITMENT DATE (YYYYMMDD):	
MILITARY BRANCH: Select one	
SERVICE TYPE: Select one	

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? Select one
Are you pregnant or nursing (currently or in past 6 months)? Select one
Have you or a family member been diagnosed with keratoconus, pellucid, or ectasia? Select one

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/		Type (soft v. hard):	OS: 20/		OS:
OS:				20/		OS:				20/					

MRx Older Than 1 Year Date:					VERIFICATION (each statement must be verified):
	Sphere	Cylinder	Axis	CDVA	☐ ≤ 0.50D change in sphere or cylinder in last 12 months
OD:				20/	☐ Pentacam or topography attached and uploaded to electronic medical record (If available)
OS:				20/	☐ No dry eyes/blepharitis or dry eyes/blepharitis managed

COMMENTS:

60th MDG DEPENDENT AND RETIREE REFRACTIVE EYE SURGERY PROGRAM (DRRESP) CENTER

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**
			Select one
HOME ADDRESS	**CITY**	**STATE**	**ZIP**

OCULAR HISTORY Check Yes/No

Do you have or have you ever had the following eye conditions?		
Amblyopia/ lazy eye	No ☐	Yes ☐
Cataracts	No ☐	Yes ☐
Conjunctivitis, recurrent	No ☐	Yes ☐
Ocular Rosacea	No ☐	Yes ☐
Double vision	No ☐	Yes ☐
Severe dry eyes	No ☐	Yes ☐
Glaucoma or high eye pressure	No ☐	Yes ☐
Ocular Herpes Simplex / Zoster	No ☐	Yes ☐
Keratoconus	No ☐	Yes ☐
Retinal problems	No ☐	Yes ☐
Trauma	No ☐	Yes ☐
Previous eye surgery or PRK/LASIK eval?	No ☐	Yes ☐

Explain any yes or indicate other eye condition not listed:

MEDICAL HISTORY Check Yes/No

Do you have or have you ever had any of the following?		
Psoriasis	No ☐	Yes ☐
Vitiligo	No ☐	Yes ☐
Rheumatoid arthritis	No ☐	Yes ☐
Ulcerative Colitis or Crohn's disease	No ☐	Yes ☐
Thyroid disease	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Heart disease or pacemaker	No ☐	Yes ☐
Autoimmune disease	No ☐	Yes ☐
Migraine headaches	No ☐	Yes ☐
Fainted/light headed during eye exam	No ☐	Yes ☐
Pregnant/Nursing in past 6 months	No ☐	Yes ☐
Planning to become pregnant within 1 year?	No ☐	Yes ☐

Other medical conditions not listed:

MEDICATIONS HISTORY Check Yes/No

Are you taking or have you ever taken any of the following?		
Accutane (isotretinoin) Date:	No ☐	Yes ☐
Immunosuppressants Date:	No ☐	Yes ☐
Steroid medication Date:	No ☐	Yes ☐
Cordarone (amiodarone)	No ☐	Yes ☐
TB meds (INH) within past 30 days	No ☐	Yes ☐
Smallpox vaccination within past 3 weeks	No ☐	Yes ☐

List all medications that you are currently taking, including over-the-counter (OTC) and any in the above list.

MEDICATION ALLERGIES Do you have any medication allergies?

Yes ☐ No ☐ If yes, list drug and reaction:

REFRACTIVE HISTORY

How many years have you worn glasses?	
Do you wear or have you ever worn bifocals?	
How many years have you worn contact lenses?	
Soft or hard lenses?	
Date you stopped wearing them (**required**)?	

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

Privacy Act of 1974 **May 2025**