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: