MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
NAVHOSPBREMINST 6490.1 CH-1	FEB 2021 (11/25 edit EFB)

LOCAL FORM TITLE *(Optional)*

REFRACTIVE SURGERY CLINIC - **LOCAL** COMMAND AUTHORIZATION FOR CORRECTIVE SURGERY

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. § 133, 1071-1087, 3012, 5031, and 8012; Executive Order 9397
PRINCIPAL PURPOSES: To facilitate and document health care. The Social Security Number is required to identify and retrieve health care records.
ROUTINE USES; Primary use of this information is to provide, plan, and coordinate health care.
DISCLOSURE: Mandatory.

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TIME SENSITIVE: WE NEED THIS AUTHORIZATION BY 1500, TUE, 1 WEEK PRIOR TO SURGERY OR SURGERY WILL BE POSTPONED!

A member of your command has the opportunity to have corrective eye surgery at Naval Hospital Bremerton.

Type of Surgery: _____ **Scheduled Surgery Date** _____ **Convalescent Leave including Surgery:** **LASIK/SMILE 2 days** **PRK 7 days**

1. Before the service member can be treated, written authorization from the member's Commanding Officer is required. Member must provide this form (completed and signed) by 1500 Tuesday week prior to surgery. ***Surgery will be canceled without this form.*** You can drop this form off at the NHB Refractive Eye Surgery Clinic front desk, fax it to (360) 475-4411 or email it to usn.kitsap.navhospbremertonwa.list.brem-rs-clinic@health.mil.
2. The primary requirement for surgery is a commitment of the service member's time for preoperative exam, surgery, convalescent leave and follow-up examinations. Required / Recommended exam intervals include:

a) Preoperative exams	Allow 1/2 day
b) Informed consent meeting	Allow 1/2 day
c) Surgery and convalescent leave	2 days LASIK/SMILE or 7days PRK
d) Immediate post-operative	Allow 1/2 day
e) One-month post-operative	Allow 1/2 day
f) Three-month post-operative	Allow 1/2 day
g) Six-month post-operative	Allow 1/2 day

3. If the service member desires or plans to receive one-, three- and six-month follow-up care from a provider other than the Refractive Surgery Clinic (only possible in some out of state cases), it requires written approval from the alternative eye care provider (below):

I understand that the service member listed above is scheduled to have laser eye surgery on the date listed above. I accept responsibility for providing follow-up care for this patient in accordance with standards of care.

_____ Eye Care Provider Printed Name/Phone Number

_____ Eye Care Provider Signature

4. Member/Commanding Officer Commitment Checklist **(Initial by each statement)**

	Member	CO
Member and CO has read and understand the information on this form.		
Member is not planning to separate or retire from the service after surgery: 6 months for Air Force and Army, 12 months for other branches of the military.		
Member and CO understand there is little flexibility in exam dates / times.		
Member and CO understand that all appointments shall be kept as scheduled.		
Member and CO understand member will have convalescent leave after surgery as listed above.		
Member and CO understand that there are risks associated with surgery and although the risks are very low, complications could result in loss of vision and member may no longer be fit for duty.		
Member and CO understand that after convalescent leave, the member **may** have an additional period of light/limited duty depending upon speed of recovery, nature of work, the work environment and until all medication is completed. **(Approximately 1 month for LASIK/SMILE and 2 months for PRK) Member cannot arm up or handle firearms for 1 month**		

5. **At NHB Refractive Surgery Clinic, we will not do surgery on those service members who knowingly have orders to deploy OCONUS a minimum of 1 month from the date of surgery for LASIK/SMILE and a minimum of 3 months from the date of surgery for PRK.**
6. **Signature of member and CO (or "By direction" authority) indicates authorization for surgery and a commitment to comply fully with follow up requirements.**

Service Member: Printed Name _____ **Commanding Officer:** Printed Name & Rank _____

Signature/Date _____ Signature/Date _____

PRACTITIONER'S NAME CLINIC USE ONLY	PRACTITIONER'S SIGNATURE CLINIC USE ONLY	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
CLINIC USE ONLY LEAVE BLANK	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	