NAVY REFRACTIVE SURGERY CONSULT FORM

FORM CON9911A01

1. Patient Input (Please print in black ink):

Last Name:

First Name: MI:

Suffix (Jr, III): Nickname:

☐ Active Duty ☐ Retired ☐ Dep FIL, MIL
☐ Reservist ☐ Dependent ☐ _____

Rank: ☐ USA ☐ USCG ☐ USN
☐ USAF ☐ USMC ☐ _____

Grade: Birthdate (DDMMYY)

Sex: ☐ M ☐ F Your SSN: - -

Sponsor's SSN (If applicable): - -

Primary NEC, MOS, Designator(s):

Unit Name:

1-2 Word Job Description:

Unit Address:

Unit City: Unit State (2 letters):

Unit Zip: Unit Country (if not US):

Unit Tel: ( ) - x

Home Address:

Home City: Home State (2 letters):

Home Zip: Home Country (If not US):

Home Area Code & Tel: ( ) -

Projected Rotation Date (DDMMYY):

End of Active Service (DDMMYY):

Pay Entry Base Date (DDMMYY):

2. Unit CO's Input:

Patient's Priority Level: 1 ☐ 2 ☐ 3 ☐ 4 ☐

Unit Co's Last Name:

Unit Co's Signature:

3. Ophthalmologist/Optometrist:

Uncorrected Visual Acuity OD: 20/(xxx): UCVA OS 20/(xxx):

	Sphere:	Cylinder:	Axis:	VA (20/xx):
RX OD:	.	.	x	
RX OS:	.	.	x	

If visual acuity with current correction is worse than 20/20, please provide a manifest refraction & BCVA:

M OD:	.	.	x	
M OS:	.	.	x	

In your professional opinion, is this patient a good candidate for refractive surgery? ☐ Yes ☐ No

☑ ≤ 0.50 D change in sphere or cylinder in last 12 months
☑ Realistic expectations about surgery
☑ No:
- Age < 21 years
- K. Sicca
- Keratoconus
- H/o HSK, HZK
- Pregnancy
- Thyroid Disease
- Diseases affecting healing: DM, Atopy, CV, AI, ID

Clinic Area Code & Tel: ( ) -

Oph/Optom Last Name:

Ophthalmolgist/ Optometrist Signature:

4. FAX completed form to (757) 953-6136

5. An e-mail confirmation will be returned to the servicemember and their unit.

Navy Refractive Surgery Center NMCP
620 John Paul Jones Circle
Portsmouth, VA 23708-2197

Tel: (757) 953-7575
Fax: (757) 953-6136

URL: http://navymedicine.med.navy.mil

Unit Admin/Personnel e-mail: @

Patient's e-mail: @