

NAVAL AVIATION REFRACTIVE SURGERY CONSULT FORM

FORM CON0003A01



1. Patient Input (Please print in black ink): **2. Unit CO's Input:**

Last Name:		
First Name:	MI:	
Suffix (Jr, III):	Call sign:	
Rank:	<input type="checkbox"/> USN <input type="checkbox"/> USMC	
Grade:	Birthdate (DDMMYY)	
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Your SSN:	
<input type="checkbox"/> PILOT <input type="checkbox"/> NFO	<input type="checkbox"/> AIRCREW	Total Hours:
Primary Aircraft:	Time in type:	
Primary NEC, MOS, Designator(s):		
Unit Name:		
Unit Address:		
Unit City:	Unit State (2 letters):	
Unit Zip:	Unit Country (if not US):	
Unit Tel:		
Home Address:		
Home City:	Home State (2 letters):	
Home Zip:	Home Country (If not US):	
Home Area Code & Tel:		
Current Upchit: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Billet: <input type="checkbox"/> DIFOPS <input type="checkbox"/> DIFDEN	Next Billet: <input type="checkbox"/> DIFOPS <input type="checkbox"/> DIFDEN
Date Beginning Work-Up Cycle (DDMMYY):		
Date Beginning Deployment (DDMMYY):		
Pay Entry Base Date (DDMMYY):		
Unit Admin/Personnel e-mail:		
@		
Patient's e-mail:		
@		

I understand that the servicemember will be medically "down" for a minimum of 4 weeks: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Unit Co's Last Name:	
Unit Co's Signature:	

3. Ophthalmologist/Optomestrist:

Uncorrected Visual Acuity OD: 20/(xxx):		UCVA OS 20/(xxx):	
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Sphere:		Cylinder:		Axis: (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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input checked="" type="checkbox"/> ≤ 0.50 D change in sphere or cylinder in last 12 months	
<input checked="" type="checkbox"/> Realistic expectations about surgery	
<input checked="" type="checkbox"/> No:	<ul style="list-style-type: none"> ♦Age < 21 years ♦K. Sicca ♦Keratoconus ♦H/o HSK, HZK
	<ul style="list-style-type: none"> ♦Pregnancy ♦Thyroid Disease ♦Diseases affecting healing: DM, Atopy, CV, AI, ID

Clinic Area Code & Tel:	
Oph/Optom Last Name:	
Ophthalmologist/Optomestrist Signature:	

4. Fax completed form to (619) 524-1731.

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

**Navy Refractive Surgery Center
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