USAF REFRACTIVE SURGERY - Post-CRS EVALUATION FORM

Date of Evaluation:

USAF-CRS Form and Tools online: https://kx.afms.mil/USAF-RS http://airforcemedicine.afms.mil/USAF-RS

Grade/ Rank	Last Name	First Name	SSN (last 4)	Management Group ☐ AASD ☐ Warfighter

CRS Treatment Location

Post-CRS Visit ____ Months

Type of CRS OD ____ OS ____

Surgery Date OD ____ OS ____

CHIEF COMPLAINT / INTERVAL HISTORY

SYMPTOMS

	Halos		Glare		Diplopia		Dry Eye		↓ Night Vision	
	OD	OS	OD	OS	OD	OS	OD	OS	OD	OS
NONE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MILD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
MOD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
SEVERE	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

UNCORRECTED VA (UCVA)

20/ ____ OD 20/ ____ OS

IOP OD ____ mmHg OS ____ mmHg

MEDICATION: If currently in use, indicate name/dosage

OD	OS		
☐	☐	Steroid	
☐	☐	IOP Control	
☐	☐	Artificial Tears	
☐	☐	Other: (explain)	

POST-CRS OPTICAL CORRECTION USE

☐ None ☐ Distance Only ☐ Near Only ☐ Both Distance & Near

AMOUNT USED, IF WORN

☐ <25% ☐ 25-50% ☐ 51-75% ☐ >75%

SLIT LAMP EXAM

OD ☐ Normal ☐ Abnormal

OS ☐ Normal ☐ Abnormal

Haze

OD ☐ 0 ☐ 0.5 (trace) ☐ 1 ☐ 2 ☐ 3 ☐ 4

OS ☐ 0 ☐ 0.5 (trace) ☐ 1 ☐ 2 ☐ 3 ☐ 4

COMPLICATIONS

	OD	OS
Corneal Erosion	☐	☐
Corneal Infiltrate/Ulcer	☐	☐
IOP >25mmHg by TA	☐	☐
Diffuse Lamellar Keratitis	☐	☐
Epithelial Ingrowth	☐	☐
Flap Complication	☐	☐

PRECISION VISION ACUITY

Std Distance = 4 meters (13.1 ft)

TEST DISTANCE USED: 4

AASD Only

	HIGH CONTRAST				5% CONTRAST			
	OD		OS		OD		OS	
	# letters	PV - VA	# letters	PV - VA	# letters	PV - VA	# letters	PV - VA
UCVA		20/		20/		20/		20/
BCVA		20/		20/		20/		20/

MANIFEST: *Refract to BEST VISUAL ACUITY (BCVA)*

	Sphere		Cylinder		Axis		ADD	
OD		-		x		20/		20/
OS		-		x		20/		20/

OVT-VA

OD **UCVA** OS: 20/ ____ 20/ ____

OD **BCVA** OS: 20/ ____ 20/ ____

OVT-DP

Correction Used ? ☐ NO ☐ YES

☐ A ☐ B ☐ C ☐ D ☐ E ☐ F

REQUIRED FOR AASD WAIVER CONSIDERATION ONLY

IMPRESSION / PLAN

Date Steroid Use Was Discontinued:

CYCLOPLEGIC REFRACTION *Refract to 20/20 VISUAL ACUITY*

OD		-		x		20/
OS		-		x		20/

DILATED FUNDUS EXAM

OD ☐ Normal ☐ Abnormal ☐ Not Performed

OS ☐ Normal ☐ Abnormal ☐ Not Performed

RECOMMENDATION: Meets Applicable Vision Standards ☐ Yes ☐ No

Recommend Return to ☐ Full ☐ Restricted Duty Status

EYECARE PROVIDER CONTACT INFORMATION

Base | Phone (DSN)

Duty

E-mail

Eye Care Provider's Signature

Eye Care Provider's Name/Rank

Pre-CRS cyclo refraction:	OD			-		x	
	OS			-		x	
Post-CRS cyclo refraction:	OD			-		x	
(page 1 is default entry. May edited)	OS			-		x	

OVT Depth Perception passed through | Haze OD: | OS:

Name : , Date of most recent appt: 1/0/1900

Surgical Procedure: OD: / OS:

Surgical Location:

Pre-CRS cyclo Refraction - OD: - x / OS: - x

Post-CRS cyclo Refraction - OD: - x / OS: - x

Manifest Refraction - OD: - x / OS: - x

UnCorrected PV High Contrast VA #VALUE!

Corrected PV High Contrast VA #VALUE!

UnCorrected PV 5% Contrast VA #VALUE!

Corrected PV 5% Contrast VA #VALUE!

IOP - OD: / OS: HAZE - OD: 0 OS: 0

OVT Depth Perception passed through

Eye Medications: past/current	
Slit Lamp Exam / Dilated Fundus Exam	
Pt reported Symptons: Glare, Halo, Diplopia, Reduced Night Vision	