DD Form 2808 Supplement for Cycloplegic Eye Refraction

TESTS REQUIRED: Cycloplegic Eye Refraction, Dilated Fundus Exam, & Color Corneal Topographies

Testing at Carlisle Barracks/Dunham AHC (eligible Active/AGR personnel):

1. Schedule appointment at Dunham AHC Optometry by calling 717-245-3400; verify all three above tests can be done.
2. Bring this form, sunglasses, and an additional driver.
3. Optometry will not see you and will reschedule if you do not have this form with you.

Testing at a Civilian Optometrist/Ophthalmologist:

1. Schedule appointment and follow instructions of optometrist; verify all three tests above can be done. Some LASIK/PRK vision centers can perform all of the above tests.
2. Bring this form, sunglasses, and an additional driver.

**** Note: All fees incurred from civilian testing are the responsibility of the patient. ****

When all tests are complete, scan (must be **COLOR**) and email this form, color corneal topographies, fundus exam results, and other pertinent documentation to ng.pa.paarng.list.eaats-med-co@mail.mil. You will be contacted once these documents have been reviewed.

Note to Patient: A cycloplegic refraction is performed by placing one drop of either 1% or 2% cyclopentolate in both eyes. It takes a few minutes for the drug to take effect, and causes sensitivity to light. Cyclopentolate has a duration of action of 2 to 24 hours. Patient is advised that they should have someone drive them to and from their appointment, and have dark sunglasses with them following the examination.

Date of Testing: _____

Distant Visual Acuity:

OD: 20/_____ Corr to 20/_____

OS: 20/_____ Corr to 20/_____

Near Visual Acuity:

OD: 20/_____ Corr to 20/_____

OS: 20/_____ Corr to 20/_____

IOP: Type:_____

OD: _____

OS: _____

Manifest Refraction:

OD: _____ S _____ Cyl _____ Axis _____ Add _____

OS: _____ S _____ Cyl _____ Axis _____ Add _____

Cycloplegic:

OD: _____ S _____ Cyl _____ Axis _____

OS: _____ S _____ Cyl _____ Axis _____

Dilated Fundus Exam: WNL / Abn

Comments: _____

_____

Facility Name and Address:

_____

_____

_____

_____

Phone: _____

Patient Name and Address:

_____

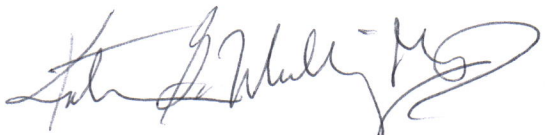
_____

_____

SSN: _____

Phone: _____

DOB: _____



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