



Orthopedic Foundation for Animals
 2300 E Nifong Blvd, Columbia, MO 65201-3806
 Phone: (573) 442-0418; Fax: (573)875-5073
 www.ofa.org. A not-for-profit organization

Companion Animal Eye Registry (CAER)

Registered name: **Wiggiebutt the Valley of Rocks**
 Breed: **Min. American Shepherd** Sex: **F**

ID Number (if any): Tattoo Microchip
981026023426137
 Registration Number: AKC other
DNS0999006
 Date of Birth (mm/dd/yy): **082517** Date of Exam (mm/dd/yy):

Owner Name: **Sayne Levine**
 Co-Owner Name: _____ Phone: _____
 Owner Address: **70 E Broadleaf Dr**
 City: **Hendersonville NC** State: _____ Zip/postal code: **28139**

E-Mail (use both lines if needed):
flayinghasa@aol.com

I hereby certify that the animal examined is the animal described on this application, and understand that the results of this exam will be submitted by the examining ophthalmologist to the database for statistical gathering purposes. I understand that only passing results will be released to the public unless the initials of a registered owner or authorized agent appear in the authorizing box below which permits the OFA to release non-passing results to the public.
 Signature of owner/authorized agent/representative: *Sayne Levine*

I hereby authorize the OFA to release the results of the evaluation of the animal described on this application to the public if the results are non-passing (initials) _____

- I DID verify microchip/tattoo on this dog
 I DID NOT verify microchip/tattoo on this dog

I certify that I have performed this ophthalmic examination using pharmacological mydriasis, ophthalmoscopy, and biomicroscopy.

Signature: _____ Date: **6/29/19**
 ACVO #: **363**

Diplomate, American College of Veterinary Ophthalmologists
FEES AND CREDIT CARD INFORMATION ON THE BACK OF THE WHITE (OWNER) COPY



442737

Ophthalmologist Name: _____
 Ophthalmologist Address: **10th Broadwater EC363**
 City: **Charlotte Animal Referral & Emergency** Zip/postal code: _____
 Phone: **704-457-2300** ACVO #: _____
 Email: _____

CORNEA	<input type="checkbox"/> T <input type="checkbox"/> N <input type="checkbox"/> P	<input type="checkbox"/> distichiasis <input type="checkbox"/> ectopic cilia <input type="checkbox"/> imperforate lacrimal punctum <input type="checkbox"/> NICTITANS <input type="checkbox"/> cartilage anomaly/eversion <input type="checkbox"/> gland prolapse <input type="checkbox"/> plasmoma/atypical pannus CORNEA <input type="checkbox"/> dystrophy — epithelial/stromal <input type="checkbox"/> dystrophy — endothelial <input type="checkbox"/> pannus <input type="checkbox"/> pigmentary keratitis/keratopathy <input type="checkbox"/> UVEA <input type="checkbox"/> free floating <input type="checkbox"/> single <input type="checkbox"/> multiple
CORNEA	<input type="checkbox"/> N <input type="checkbox"/> T <input type="checkbox"/> P	<input type="checkbox"/> endothelial opacity/no strands <input type="checkbox"/> lens pigment foci/no strands <input type="checkbox"/> iris sheets <input type="checkbox"/> iris to cornea <input type="checkbox"/> iris to lens <input checked="" type="checkbox"/> iris to iris <input type="checkbox"/> persistent pupillary membranes <input type="checkbox"/> uveal cyst <input type="checkbox"/> iris coloboma <input type="checkbox"/> iris hypoplasia <input type="checkbox"/> iris sphincter dysplasia <input type="checkbox"/> pigmentary uveitis <input type="checkbox"/> uveal melanoma <input type="checkbox"/> multiple <input type="checkbox"/> single <input type="checkbox"/> free floating

CATARACT	<input type="checkbox"/> Incomp. <input type="checkbox"/> Incip. <input type="checkbox"/> Punc.	<input type="checkbox"/> anterior cortex <input type="checkbox"/> posterior cortex <input type="checkbox"/> equatorial cortex <input type="checkbox"/> anterior sutures <input type="checkbox"/> posterior sutures <input type="checkbox"/> nucleus <input checked="" type="checkbox"/> capsular <input type="checkbox"/> generalized/complete <input type="checkbox"/> resorbing/hypermature
CATARACT	<input type="checkbox"/> Punc. <input type="checkbox"/> Incip. <input type="checkbox"/> Incomp.	<input type="checkbox"/> anterior cortex <input type="checkbox"/> posterior cortex <input type="checkbox"/> equatorial cortex <input type="checkbox"/> anterior sutures <input type="checkbox"/> posterior sutures <input type="checkbox"/> nucleus <input type="checkbox"/> capsular <input type="checkbox"/> generalized/complete <input type="checkbox"/> resorbing/hypermature

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/> detached <input type="checkbox"/> geographic <input type="checkbox"/> folds	<input type="checkbox"/> retinal detachment <input type="checkbox"/> retinal atrophy—generalized <input type="checkbox"/> retinopathy <input type="checkbox"/> retinal dysplasia	<input type="checkbox"/> folds <input type="checkbox"/> geographic <input type="checkbox"/> detached
<input type="checkbox"/> choroidal hypoplasia <input type="checkbox"/> coloboma <input type="checkbox"/> optic nerve coloboma <input type="checkbox"/> optic nerve hypoplasia <input type="checkbox"/> micropapilla	OTHER CONDITIONS <input type="checkbox"/> Unlisted conditions suspected as inherited. Describe in comments <input type="checkbox"/> Unlisted conditions suspected as not inherited	

NORMAL

ant. chamber <input type="checkbox"/> syneresis	<input type="checkbox"/> subluxation/luxation VITREOUS <input type="checkbox"/> PHPV/PHTVL <input type="checkbox"/> persistent hyaloid artery <input type="checkbox"/> degeneration	<input type="checkbox"/> syneresis <input type="checkbox"/> ant. chamber
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Comments _____