



# 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

Call Name:	<b>KONA</b>
Registered Name:	<b>BAR-KL WIGGLEBUTT KONA</b>
Sex/Breed:	<b>M MINIATURE AMERICAN SHEPHERD</b>
Microchip/Tattoo:	
Registration No:	<b>DN64122605</b>
Date of Birth:	<b>09/30/2020</b>
Owner Name:	<b>ANGELA OGLE</b>
Co-owner Name:	<b>KATHY FRANK</b>
Owner Address:	<b>404 BROOKWOOD COURT</b>
City/State/Postal:	<b>VALPARAISO IN 46385</b>
Email:	<b>minis@wiggleb.com</b>
Telephone:	<b>219-465-1624</b>

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 authorization box below which permits the OFA to release non-passing results to the public. **I further understand that ALL results, both passing and non-passing, will be made available to ophthalmologists who may examine this dog at a future date.**

Signature of owner or authorized agent/representative

**04/24/2021**

Date of Exam (mm/dd/yyyy)

<input type="checkbox"/>	I DID verify the microchip/tattoo on this dog.
<input type="checkbox"/>	I DID NOT verify the microchip/tattoo on this dog.
<input type="checkbox"/>	NO MICROCHIP/TATTOO PRESENT

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

Signature/ACVO#/Date

Exam registration number:



**217LNV**

# Companion Animal Eye Registry (CAER)

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	keratoconjunctivitis sicca	<input type="checkbox"/>
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
<b>EYELIDS</b>		
<input type="checkbox"/>	entropion	<input type="checkbox"/>
<input type="checkbox"/>	ectropion	<input type="checkbox"/>
<input type="checkbox"/>	distichiasis	<input type="checkbox"/>
<input type="checkbox"/>	ectopic cilia	<input type="checkbox"/>
<input type="checkbox"/>	imperforate lacrimal punctum	<input type="checkbox"/>
<b>NICTITANS</b>		
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>
<b>CORNEA</b>		
<input type="checkbox"/>	dystrophy — epithelial/stromal	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy — endothelial	<input type="checkbox"/>
<input type="checkbox"/>	pannus	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary keratitis/keratopathy	<input type="checkbox"/>
<b>UVEA</b>		
<input type="checkbox"/>	uveal cyst	<input type="checkbox"/>
<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
<input type="checkbox"/>	iris hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	iris sphincter dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>
<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>
<b>LENS</b>		
<input type="checkbox"/>	anterior cortex	<input type="checkbox"/>
<input type="checkbox"/>	posterior cortex	<input type="checkbox"/>
<input type="checkbox"/>	equatorial cortex	<input type="checkbox"/>
<input type="checkbox"/>	anterior sutures	<input type="checkbox"/>
<input type="checkbox"/>	posterior sutures	<input type="checkbox"/>
<input type="checkbox"/>	nucleus	<input type="checkbox"/>
<input type="checkbox"/>	capsular	<input type="checkbox"/>
<input type="checkbox"/>	generalized/complete	<input type="checkbox"/>
<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>
<b>VITREOUS</b>		
<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

Ophthalmologist:	<b>DR. WENDY TOWNSEND</b>
Clinic Name:	
ACVO #:	<b>254</b>
Phone:	

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>
<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>
<input type="checkbox"/>	CMR/CMR-like retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	other presumed inherited retinopathy	<input type="checkbox"/>
<b>retinal dysplasia</b>		
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	coloboma	<input type="checkbox"/>
<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>
<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	micropapilla	<input type="checkbox"/>
<b>OTHER CONDITIONS</b>		
<input type="checkbox"/>	Unlisted conditions suspected as <b>inherited</b> . Describe in comments	
<input type="checkbox"/>	Unlisted conditions suspected as <b>not inherited</b>	
<b>NORMAL</b>		

Comments