



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)

Call name: **Poppy**
 Registered name: **Lakeside Brookside Poppin Bottles**
 Breed: **Labrador Retriever** Sex: **F**
 ID Number (if any): Tattoo Microchip
985112005435707
 Registration Number: AKC Other
SS30252701
 Date of Birth (mm/dd/yy): **1/00321** Date of Exam (mm/dd/yy): **04/0123**

Owner Name: **Kali Hobash + Kerri Holdash**
 Co-Owner Name: _____ Phone: **2165712893**
 City: _____ State: **OH** Zip/postal code: _____
 E-Mail (use both lines if needed):
ohiobrooksidelab@gmail.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 authorization box below which permits the OFA to release non-passing results to the public.

[Signature]
 Signature of owner or authorized agent/representative

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) *[Signature]*

I DID verify microchip/tattoo on this dog
 I DID NOT verify microchip/tattoo on this dog
 NO MICROCHIP/TATTOO PRESENT

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

Signature: *[Signature]* ACVO # _____ Date: **04/1/23**
 Diplomat, American College of Veterinary Ophthalmologists

FEEES AND CREDIT CARD INFORMATION ON THE BACK OF THE WHITE (OWNER) COPY



832663

WHITE = Owner/OFA Registration copy; PINK = ACVO Diplomat copy; YELLOW = ACVO Research copy

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"/>
EYELIDS		
<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"/>
NICTITANS		
<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"/>
CORNEA		
<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"/>
UVEA		
<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"/>
persistent pupillary membranes		
LENS		
<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"/>
<input type="checkbox"/> Significance Unknown/Suspect Not Inherited		
<input type="checkbox"/>	posterior Y-suture tip opacities	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
VITREOUS		
<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
degeneration		

Ophthalmologist Name: _____
 Ophthalmologist Address: _____
 City: _____ State: _____ Zip/postal code: _____
 Phone: **Bill Greentree, DVM, DACVO**
Veterinary Ophthalmologist EC208
GreentreeDVM@gmail.com
 Email: _____

RIG (644) FUNDUS 2 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"/>
<input type="checkbox"/>	retinal dysplasia	<input type="checkbox"/>
<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"/>
OTHER CONDITIONS		
<input type="checkbox"/>	Unlisted conditions suspected as inherited. Describe in comments	<input type="checkbox"/>
<input type="checkbox"/>	Unlisted conditions suspected as not inherited	<input type="checkbox"/>

NORMAL

Comments
