



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: **CLINTON OAKS JOURNEY OVER FIELDS OF CLOVER**

Breed: **VIZSLA** Sex: **F**

ID Number (if any): Tattoo Microchip
956000008512996

Registration Number: AKC Other
SR71155603

Date of Birth: **010212** Date of Exam: **021414**

Owner/Co-owner Name: **GINA FOX**

Co-Owner Name: _____ Phone: _____

Owner Address: **PO BOX 230 10306 LOS LAKE TRC**

City: **MANDELONA** State: **ME** Zip/postal code: **94659**

E-Mail (use both lines if needed): **GINAVESCO@AOL.COM**

I hereby certify that the animal examined is the animal described on this application. I understand that only non-passing results will be released to the public unless the initials of a registered owner 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) _____

OFA Eye Clearance Database

- Initial submission \$12.00
- Resubmits: \$8.00
- Litter of 3 or more submitted together \$30.00
- Kennel Rate—Minimum of 5 individuals submitted as a group, owned/co-owned by same person. \$7.50 ea.
- Submission of non-passing results in the open database: NO CHARGE

Payments can be made by check, money order (U.S. funds drawn on a U.S. bank), cash, Visa, or Mastercard, payable to the Orthopedic Foundation for Animals.

To pay by Credit Card, see the back of the WHITE sheet.

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"/>
	CORNEA	
<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"/>	exposure/pigmentary keratitis	<input type="checkbox"/>
	UYEA	
<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"/>
<input type="checkbox"/>	persistent pupillary membranes	<input type="checkbox"/>
	LENS	
<input type="checkbox"/>	Incomp. <input type="checkbox"/> Incip. <input type="checkbox"/> Punc. <input type="checkbox"/>	<input type="checkbox"/>
<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 of cataract unknown	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
	VITREOUS	
<input type="checkbox"/>	PHPV/PTVL	<input type="checkbox"/>
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

Ophthalmologist Name: **Dan Lorimer**

Ophthalmologist Address: **29080 Inkster Rd**

City: **Southfield** State: **MI** Zip/postal code: **48034**

Phone: **(248) 354-6660** ACVO #: _____

Email: **Dan.Lorimer@bluepearlvet.com**

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"/>	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

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: *[Signature]* ACVO # **128** Date: **2-14-14**

Diplomate, American College of Veterinary Ophthalmologists

Comments