



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: **Everso Free Labrador Retriever** Sex: **male**
 Number (Fay) Title Microchip

Registration Number: **SR955015101**
 Date of Birth (mm/yy): **070816** Date of Exam (mm/yy): **080117**

Owner Name: **Stefanie Ferrine**
 Co-Owner Name: _____ Phone: _____

Owner Address: **4990 Kipling St #16 Wheat Ridge CO 80033**
 City: _____ State: _____ Zip/postal code: _____
 E-Mail (use both lines if needed): _____

I hereby certify that the animal examined is the animal described in this application, and understand that the results of this exam will be submitted by the examining ophthalmologist to the database for statistical purposes. I understand that only passing results will be released to the public, and the results of a registered owner or registered agent appear in the author's name, but the results of a registered owner or registered agent appear in the author's name, but the results of a registered owner or registered agent appear in the author's name, but the results of a registered owner or registered agent appear in the author's name.

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)

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: **Todd Hammond** ACVO # **83** Date: **8/1/17**

Diplomate, American College of Veterinary Ophthalmologists

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



407450

Ophthalmologist: **Todd Hammond, DVM, MS, DACVO**
 Ophthalmologist Address: **7630 W. 39th Avenue**
 City: _____ State: _____ Zip/postal code: _____
 Phone: _____
 Email: **(303) 422-7444 ACVO # 83**

RIGHT EYE		GLOBE	LEFT EYE	
<input type="checkbox"/>	<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	keratoconjunctivitis sicca	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
EYELIDS				
<input type="checkbox"/>	<input type="checkbox"/>	entropion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ectropion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	distichiasis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ectopic cilia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	imperforate lacrimal punctum	<input type="checkbox"/>	<input type="checkbox"/>
NICITANS				
<input type="checkbox"/>	<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>	<input type="checkbox"/>
CORNEA				
<input type="checkbox"/>	<input type="checkbox"/>	dystrophy — epithelial/stromal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	dystrophy — endothelial	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	pannus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	pigmentary keratitis/keratopathy	<input type="checkbox"/>	<input type="checkbox"/>
UVEA				
<input type="checkbox"/>	<input type="checkbox"/>	uveal cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	iris hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	iris sphincter dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	persistent pupillary membranes	<input type="checkbox"/>	<input type="checkbox"/>
LENS				
<input type="checkbox"/>	<input type="checkbox"/>	anterior cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	posterior cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	equatorial cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	anterior sutures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	posterior sutures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	nucleus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	capsular	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	generalized/complete	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	suspect not inherited	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>	<input type="checkbox"/>
VITREOUS				
<input type="checkbox"/>	<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	degeneration	<input type="checkbox"/>	<input type="checkbox"/>

RIGHT EYE		FUNDUS	LEFT EYE	
<input type="checkbox"/>	<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	micropapilla	<input type="checkbox"/>	<input type="checkbox"/>

OTHER CONDITIONS

Unlisted conditions suspected as inherited. Describe in comments _____

Unlisted conditions suspected as not inherited _____

NORMAL

Comments
