

Roxie



Orthopedic Foundation for Animals

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

Companion Animal Eye Registry (CAER)

Registered name: Roxy
 Breed: Goldendoodle Sex: F
 ID Number (if any): Tattoo Microchip
 Registration Number: AKC Other
 Date of Birth (mm/dd/yy): 09/25/18 Date of Exam (mm/dd/yy):
 Owner Name: Callie Brown, Goldendoodles
 Co-Owner Name: _____ Phone: Forever
 Owner Address: 14987 Budd Rd
 City: Dubuque State: IA Zip/postal code: 52002
 E-Mail (use both lines if needed):
calliebrown@ruhl
homes.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.

Callie O. Brown
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 no chip

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

Signature: Dr. Paul E. Miller ACVO # 129 Date: 18 Feb 2019
Diplomate, American College of Veterinary Ophthalmologists

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



438284

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"/>			
NICITANS					
<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"/>			
<input type="checkbox"/> persistent pupillary membranes					
LENS					
CATARACT	Incomp. Incip. Punc. Punc. Incip. Incomp.	CATARACT			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anterior cortex	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	equatorial cortex	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	posterior sutures	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	capsular	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> suspect not inherited					
<input type="checkbox"/> subluxation/luxation					
VITREOUS					
<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>			
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>			
<input type="checkbox"/> degeneration					

Ophthalmologist Name: _____
 Ophthalmologist Address: Dr. Paul E. Miller EC129
University of Wisconsin
 City: Madison, WI State: WI Zip/postal code: _____
 Phone: 608-263-5066 ACVO #: _____
 Email: _____

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"/>	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"/> Unlisted conditions suspected as not inherited		

NORMAL

Comments
