



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

Registered name: **ASKEW VONTIGHE HAUS**

Breed: **GERMAN SHEPHERD DOG** Sex: **F**

ID Number (if any): Tattoo Microchip
956000003601767

Registration Number: AKC Other
BS574000

Date of Birth: **09/24/14** Date of Exam: **07/07/16**

Owner Name: **LEE HANRAHAN**

Co-Owner Name: _____ Phone: **6132939717**

Owner Address: **2244 MCGOVERN**

City: **OXFORD MILLS** State: **ON** Zip/postal code: **K0G 1S0**

E-Mail (use both lines if needed):
UNLIMITEDGSD@ME.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]*

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
- 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.



316883

Companion Animal Eye Registry (CAER)

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

Ophthalmologist Name: _____

Ophthalmologist Address: **Dr. David Tinsley**

City: **EC 176** State: _____ Zip/postal code: _____

Ophthalmology Referral Service #0 #: _____

Email: **613-520-2214**

RIGHT EYE		FUNDUS	LEFT EYE	
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	retinopathy	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	retinal dysplasia			<input type="checkbox"/>
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	coloboma	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	micropapilla	<input type="checkbox"/>	<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 # **176** Date **7/7/16**

Diplomate, American College of Veterinary Ophthalmologists

Comments
