

OWNER: Rick Marshall Phone: 2162926247
 ADDRESS (Street & No., City, Zip Code): 24419 Duffield Rd. Dorchester PA 44122
 Animal Registered Name: Becraft Cooper
 Breed/Variety: Labrador Coat color/type: cream Permanent ID#: 082262342



**CANINE EYE
REGISTRATION
FOUNDATION**

255

Margaret A. Foss, DVM, DACVO

For litters, add number.

I hereby declare that the animal submitted for exam is the animal described above. Furthermore, I declare I am the owner or agent of the owner of this animal.

Signature: [Signature]

PRESS FIRMLY.

FILL COMPLETELY.

SEX
 Male Female

BIRTH DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

EXAM DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

FOR CERF USE ONLY

BREED: LAB COLOR: CR
 CORNEA: T 0 N 0
 A 0 P 0
 Uvea: T 0 N 0
 A 0 P 0
 Cataract: T 0 N 0
 A 0 P 0

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	dry eye	<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"/>	ectropion	<input type="checkbox"/>
<input type="checkbox"/>	distichiasis	<input type="checkbox"/>
<input type="checkbox"/>	ectopic cilia	<input type="checkbox"/>
<input type="checkbox"/>	eury/macro blepharon	<input type="checkbox"/>
<input type="checkbox"/>	THIRD EYELID	<input type="checkbox"/>
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	CORNEA	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy -- epithelial/stromal	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy -- endothelial	<input type="checkbox"/>
<input type="checkbox"/>	inherited pannus	<input type="checkbox"/>
<input type="checkbox"/>	exposure/pigmentary keratitis	<input type="checkbox"/>
<input type="checkbox"/>	UVEA	<input type="checkbox"/>
<input type="checkbox"/>	iris/ciliary body cyst	<input type="checkbox"/>
<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
<input type="checkbox"/>	iris hypoplasia/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"/>
<input type="checkbox"/>	LENS	<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	<input type="checkbox"/>
<input type="checkbox"/>	significance of above cataract unknown (describe in comments)	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
<input type="checkbox"/>	VITREOUS	<input type="checkbox"/>
<input type="checkbox"/>	PHPV/PTVL	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	retinal atrophy -- generalized	<input type="checkbox"/>
<input type="checkbox"/>	retinal atrophy -- suspicious	<input type="checkbox"/>
<input type="checkbox"/>	retinal dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	staphyloma/coloboma	<input type="checkbox"/>
<input type="checkbox"/>	retinal detachment	<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"/>
<input type="checkbox"/>	OTHER UNLISTED CONDITIONS	<input type="checkbox"/>
<input type="checkbox"/>	OTHER	<input type="checkbox"/>
<input type="checkbox"/>	NORMAL	<input type="checkbox"/>

DUPLICATE FORM
 This dog's microchip has been scanned and matches the number provided on the form.

I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.
 Signature: [Signature] Date: 9/7/11
 Diplomate, American College of Veterinary Ophthalmologists

COMMENTS

ACVO #

Owner Copy

Please note to ensure proper registration this original owner's copy must be mailed directly to CERF