



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)

RIGHT EYE **GLOBE** LEFT EYE

- microphthalmos
- keratoconjunctivitis sicca
- glaucoma
- EYELEIDS**
- entropion
- ectropion
- distichiasis
- ectopic cilia
- imperforate lacrimal punctum
- NICTITANS**
- cartilage anomaly/eversion
- gland prolapse
- plasmoma/atypical pannus
- CORNEA**
- dystrophy — epithelial/stromal
- dystrophy — endothelial
- pannus
- pigmentary keratitis/keratopathy
- UVEA**
- uveal cyst
- iris coloboma
- iris hypoplasia
- iris sphincter dysplasia
- pigmentary uveitis
- uveal melanoma
- persistent pupillary membranes
- iris to iris
- iris to lens
- iris to cornea
- iris sheets
- lens pigment foci/no strands
- endothelial opacity/no strands
- free floating
- single
- multiple
- multiple
- single
- free floating

Ophthalmologist Name: _____

Ophthalmologist Address: _____

City: _____ State: _____ Zip/postal code: _____

Phone: _____

Email: _____

Dr. Neal Wasserman EC426
Eye Care for Animals
Wheeling, IL
847-215-3933

RIGHT EYE **FUNDUS** LEFT EYE

- detached
- geographic
- folds
- retinal detachment
- retinal atrophy — generalized
- retinopathy
- retinal dysplasia
- choroidal hypoplasia
- coloboma
- optic nerve coloboma
- optic nerve hypoplasia
- micropapilla
- folds
- geographic
- detached

- OTHER CONDITIONS**
- Unlisted conditions suspected as inherited. Describe in comments
 - Unlisted conditions suspected as not inherited

NORMAL

Comments

CATARACT	INCIP.	PUNC.	PUNC.	INCIP.	INCIP.	CATARACT
<input type="checkbox"/> T	<input type="checkbox"/> Incomp.	<input type="checkbox"/> Incip.	<input type="checkbox"/> Punc.	<input type="checkbox"/> Incip.	<input type="checkbox"/> Incomp.	<input type="checkbox"/> N
<input type="checkbox"/> N	<input type="checkbox"/> anterior cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> T
<input type="checkbox"/> P	<input type="checkbox"/> posterior cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> A
<input type="checkbox"/>	<input type="checkbox"/> equatorial cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> N
<input type="checkbox"/>	<input type="checkbox"/> anterior sutures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> T
<input type="checkbox"/>	<input type="checkbox"/> posterior sutures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> P
<input type="checkbox"/>	<input type="checkbox"/> nucleus	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>
<input type="checkbox"/>	<input type="checkbox"/> generalized/complete	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> Significance Unknown/Suspect Not Inherited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> subluxation/luxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> VITREOUS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> PHPV/PHTVL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> ant. chamber	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/> syneresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Call name: **TRAY**

Registered name: **Catsie Something To Talk About**

Breed: **CKCS** Sex: **M**

ID Number (if any): Tattoo **991003000570944**

Registration Number: DAK Other **7549191803**

Date of Birth (mm/dd/yy): **010521** Date of Exam (mm/dd/yy): **032921**

Owner Name: **Myron Miller**

Co-Owner Name: _____

Phone: **330-231-6927**

Owner Address: **3528 Township Rd 374**

City: **Millersburg** State: **OH** Zip/postal code: **44654**

E-Mail (use both lines if needed): _____

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 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 MICROCHIP/TATTOO PRESENT

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

Signature: **Neal Wasserman** ACVO # _____ Date: **426 3/20/21**

Diplomate, American College of Veterinary Ophthalmologists

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



677046

WHITE = Owner/OFA Registration copy; PINK = ACVO Diplomat copy; YELLOW = ACVO Research copy

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02/27/19