



**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: **JARS' TIK-TAK-TOE TIKI**  
 Breed: **AUSTRALIAN LABRADOODLE** Sex: **FEMALE**  
 ID Number (if any):  Tattoo  Microchip  
**837\*022\*000**  
 Registration Number:  ARC  Other  
 Date of Birth (mm/dd/yy): **030616** Date of Exam (mm/dd/yy): **031519**  
 Owner Name: **JUSTIN RIEGSECKER**  
 Co-Owner Name: **[REDACTED]**  
 Owner Address: **[REDACTED]**  
 City: **WAUSEON** State: **OH** Zip/postal code: **43567**  
 E-Mail (use both lines if needed):  
**JARSLABRADOODLES**  
**@GMAIL.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 below which permits the OFA to release non-passing results to the public.

*Justin Riegsecker*  
 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: *[Signature]* ACVO # **617** Date: **3/15/19**  
 Diplomate, American College of Veterinary Ophthalmologists

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



505413

**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"/>	
<b>EVELIDS</b>				
<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"/>	
<b>NICTITANS</b>				
<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"/>	
<b>CORNEA</b>				
<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"/>	
<b>UVEA</b>				
<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"/>	
<b>persistent pupillary membranes</b>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LENS</b>				
<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"/>
<b>suspect not inherited</b>				
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VITREOUS</b>				
<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"/>
<b>degeneration</b>				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Ophthalmologist Name: \_\_\_\_\_  
 Oph: **Dr. David J Haeussler Jr EC 517**  
 City: **The Animal Eye Institute** Postal code: \_\_\_\_\_  
**Cincinnati, OH**  
 Pho: **513-374-3963**  
 Em: \_\_\_\_\_

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"/>	
<b>retinal dysplasia</b>				
<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"/>	microcapilla	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OTHER CONDITIONS</b>				
<input type="checkbox"/>	Unlisted conditions suspected as <b>inherited</b> . Describe in comments			<input type="checkbox"/>
<input type="checkbox"/>	Unlisted conditions suspected as <b>not inherited</b>			<input type="checkbox"/>

**NORMAL**

Comments
