



Orthopedic Foundation for Animals
 2300 E Niwong 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)

Registered name: **CRYSTAL CREEK'S TITAN**
 Breed: **AUSTRALIAN LABRADORRE** Sex: **MALE**
 ID Number (if any): **038#119*009**
 Registration Number: **031519**
 Date of Birth (mm/dd/yy): **120714** Date of Exam (mm/dd/yy): **031519**

Owner Name: **JUSTIN RIESECKER**
 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.

Signature of owner or authorized agent representative
Justin Riesecker

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]* Date: **3/15/19**
 ACVO *[Signature]*

Diplomate, American College of Veterinary Ophthalmologists
FEES AND CREDIT CARD INFORMATION ON THE BACK OF THE WHITE (OWNER) COPY



505407

RIGHT EYE **GLOBE** **LEFT EYE**

microphthalmos
 keratoconjunctivitis sicca
 glaucoma
 EYELIDS
 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

Ophthalmologist Name: **Dr. David J Haussler Jr EC 517**
The Animal Eye Institute
 Cincinnati, OH
 513-374-3963

ophi: _____
 city: _____
 phone: _____
 fax: _____

istal code: _____

CORNEA	<input type="checkbox"/> T <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> endothelial opacity/no strands <input type="checkbox"/> lens pigment foci/no strands <input type="checkbox"/> iris sheets <input type="checkbox"/> iris to cornea <input type="checkbox"/> iris to lens <input type="checkbox"/> iris to iris	<input type="checkbox"/> free floating <input type="checkbox"/> single <input type="checkbox"/> multiple	<input type="checkbox"/> persistent pupillary membranes	LENS	<input type="checkbox"/> iris to iris <input type="checkbox"/> iris to lens <input type="checkbox"/> iris to cornea <input type="checkbox"/> iris sheets <input type="checkbox"/> lens pigment foci/no strands <input type="checkbox"/> endothelial opacity/no strands
CATARACT	Incomp. <input type="checkbox"/> Incip. <input type="checkbox"/> Punc. <input type="checkbox"/>	Incomp. <input type="checkbox"/> Incip. <input type="checkbox"/> Punc. <input type="checkbox"/>	<input type="checkbox"/> anterior cortex <input type="checkbox"/> posterior cortex <input type="checkbox"/> equatorial cortex <input type="checkbox"/> anterior sutures <input type="checkbox"/> posterior sutures <input type="checkbox"/> nucleus <input type="checkbox"/> capsular <input type="checkbox"/> generalized/complete <input type="checkbox"/> resorbing/hypermature	<input type="checkbox"/> anterior cortex <input type="checkbox"/> posterior cortex <input type="checkbox"/> equatorial cortex <input type="checkbox"/> anterior sutures <input type="checkbox"/> posterior sutures <input type="checkbox"/> nucleus <input type="checkbox"/> capsular <input type="checkbox"/> generalized/complete <input type="checkbox"/> resorbing/hypermature	<input type="checkbox"/> subluxation/luxation <input type="checkbox"/> VITREOUS <input type="checkbox"/> PHPV/PTVL <input type="checkbox"/> persistent hyaloid artery <input type="checkbox"/> degeneration	<input type="checkbox"/> ant. chamber <input type="checkbox"/> syneresis	<input type="checkbox"/> ant. chamber <input type="checkbox"/> syneresis

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

OTHER CONDITIONS

Unlisted conditions suspected as inherited. Describe in comments
 Unlisted conditions suspected as not inherited

NORMAL

Comments
