



**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)**

Registered name: One Pinds Black Velvet  
Breed: Mini American Shep Sex: F

ID Number (if any):  tattoo  Microchip 95100000253181842

Registration number:  AKC  Other DM34335104

Date of Birth: 101811 Date of Exam: 100614

Owner Name: Belli Reichert

Co-Owner Name: \_\_\_\_\_ Phone: 816 740 8553

Owner Address: 1945 Robinson Rd

City: Woodland State: Mo Zip/postal code: 67087

E-Mail (use both lines if needed): lonepindsear@yanho.com

I hereby certify that the animal examined is the animal described on this application. I understand that only normal results will be released to the public unless the initials of a registered owner 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: Belli Reichert

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) \_\_\_\_\_

**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 ea.
- 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.

4/14/14

193047

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

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<b>RIGHT EYE</b>	<b>GLOBE</b>	<b>LEFT EYE</b>
<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>EYELIDS</b>	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>	<input type="checkbox"/>
<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"/>	<input type="checkbox"/>
<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"/>	<input type="checkbox"/>
<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>LENS</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> persistent pupillary membranes	<input type="checkbox"/>	<input type="checkbox"/>

Ophthalmologist Name: Dr. Paul Scherlie  
 Ophthalmologist Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip/postal code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ ACVO #: \_\_\_\_\_  
 Email: \_\_\_\_\_

<b>CORNEA</b>	<input type="checkbox"/> free floating	<input type="checkbox"/> single	<input type="checkbox"/> multiple
<input type="checkbox"/> endothelial opacity/no strands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> lens pigment foci/no strands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris sheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris to cornea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris to lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris to iris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CORNEA</b>	<input type="checkbox"/> multiple	<input type="checkbox"/> single	<input type="checkbox"/> free floating
<input type="checkbox"/> iris to iris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris to lens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris to cornea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> iris sheets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> lens pigment foci/no strands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> endothelial opacity/no strands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>RIGHT EYE</b>	<b>FUNDUS</b>	<b>LEFT EYE</b>
<input type="checkbox"/> detached	<input type="checkbox"/> retinal detachment	<input type="checkbox"/>
<input type="checkbox"/> geographic	<input type="checkbox"/> retinal atrophy—generalized	<input type="checkbox"/>
<input type="checkbox"/> folds	<input type="checkbox"/> retinopathy	<input type="checkbox"/>
<input type="checkbox"/> retinal dysplasia	<input type="checkbox"/>	<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"/>
<b>OTHER CONDITIONS</b>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unlisted conditions suspected as inherited. Describe in comments	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Unlisted conditions suspected as not inherited	<input type="checkbox"/>	<input type="checkbox"/>

<b>CATARACT</b>	Incomp.	Incip.	Punc.	Incip.	Incomp.	<b>CATARACT</b>
<input type="checkbox"/> anterior cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> equatorial cortex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> posterior sutures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<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 of cataract unknown	<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"/> ant. chamber	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> syneresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>VITREOUS</b>	<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"/> persistent hyaloid artery	<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"/> syneresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ant. chamber	<input type="checkbox"/>	<input type="checkbox"/>	<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] Date: 153 10-5-14  
ACVO #: \_\_\_\_\_  
Diplomate, American College of Veterinary Ophthalmologists

Comments: \_\_\_\_\_