

OWNER Phone
 ADDRESS (Street & No., City, Zip Code)
 Animal Registered Name
 Breed/Variety Coat color/type Permanent ID#



246
 Brian Skorobohach, DVM, DACVO
 Care Center
 7140 12th Street SE
 Calgary, Alberta, CAN T2H 2V4
 (403)-520-8387

For litters, add number.

REGISTRATION NO.											
0	0	0	0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9	9	9	9
A	A	A	A	A	A	A	A	A	A	A	A
B	B	B	B	B	B	B	B	B	B	B	B
C	C	C	C	C	C	C	C	C	C	C	C
D	D	D	D	D	D	D	D	D	D	D	D
E	E	E	E	E	E	E	E	E	E	E	E
F	F	F	F	F	F	F	F	F	F	F	F
G	G	G	G	G	G	G	G	G	G	G	G
H	H	H	H	H	H	H	H	H	H	H	H
I	I	I	I	I	I	I	I	I	I	I	I
J	J	J	J	J	J	J	J	J	J	J	J
K	K	K	K	K	K	K	K	K	K	K	K
L	L	L	L	L	L	L	L	L	L	L	L
M	M	M	M	M	M	M	M	M	M	M	M
N	N	N	N	N	N	N	N	N	N	N	N
O	O	O	O	O	O	O	O	O	O	O	O
P	P	P	P	P	P	P	P	P	P	P	P
Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q	Q
R	R	R	R	R	R	R	R	R	R	R	R
S	S	S	S	S	S	S	S	S	S	S	S
T	T	T	T	T	T	T	T	T	T	T	T
U	U	U	U	U	U	U	U	U	U	U	U
V	V	V	V	V	V	V	V	V	V	V	V
W	W	W	W	W	W	W	W	W	W	W	W
X	X	X	X	X	X	X	X	X	X	X	X
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Z	Z	Z	Z	Z	Z	Z	Z	Z	Z	Z	Z

"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

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	COLOR
A	0
B	1
C	2
D	3
E	4
F	5
G	6
H	7
I	8
J	9
K	0
L	1
M	2
N	3
O	4
P	5
Q	6
R	7
S	8
T	9
U	0
V	1
W	2
X	3
Y	4
Z	5

456047

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"/>	upper lower	lower upper
EYELIDS		
<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"/>
THIRD EYELID		
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
CORNEA		
<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"/>
UVEA		
<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"/>
LENS		
<input type="checkbox"/>	Diff. Inter. Punc.	Punc. Inter. Diff.
<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"/>
VITREOUS		
<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/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 suspected as inherited. Describe in comments.	<input type="checkbox"/>
<input type="checkbox"/>	OTHER conditions suspected as not inherited	<input type="checkbox"/>
<input type="checkbox"/>	NORMAL	<input type="checkbox"/>
<input type="checkbox"/>	DUPLICATE FORM	<input type="checkbox"/>
<input type="checkbox"/>	This dog's microchip has been scanned and matches the number provided on the form.	<input type="checkbox"/>
I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.		
Signature		Date
Diplomate, American College of Veterinary Ophthalmologists		
COMMENTS		

ACVO # 190
 0 0 0
 1 1 1
 2 2 2
 3 3 3
 4 4 4
 5 5 5
 6 6 6
 7 7 7
 8 8 8
 9 9 9