



Orthopedic Foundation for Animals
 2300 E Niang 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)

Call name: **ZAC**
 Registered name: **Ch. Share-Jam ZAC PoseN**
 Breed: **Labrador Retriever** Sex: **Male**

Microchip tattoo: **45600005207771**
 Registration Number: **SR96665101**
 Date of Birth (mm/dd/yy): **12/16/16** Date of Exam (mm/dd/yy): **01/30/22**

Owner Name: **Sharon Celentano**
 Owner Name: **James Celentano** Phone: **875-564-609**
 Owner Address: **4 Midonlight Drive**
 City: **Walkkill** State: **NY** Zip/postal code: **12584**

E-mail (use both lines if needed): **SHARJAM@AOL.COM**
R.R. @ AOL.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 box below which permits the OFA to release non-passing results to the public. Further understand that ALL results, both passing and non-passing, will be made available to ophthalmologists who may examine this dog at a future date.
 Signature of owner or authorized agent/representative: **Sharon Celentano**

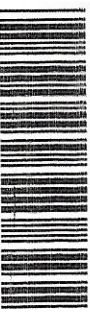
I hereby authorize the OFA to release the results of the evaluation of the animal described on this application to the public if the results are non-passing (initials) _____

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: **Michael J. Ringle** ACVO # **160130622** Date _____

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



728737

Ophthalmologist Name: **Dr. Michael J. Ringle**
 Ophthalmologist Address: **EC 160 Red Bank Veterinary Hospital 732-747-5036**
 City: **Red Bank** State: **MD** Zip/postal code: **21156**
 Phone: **732-747-5036** Email: _____

	RIGHT EYE	GLOBE	LEFT EYE
CORNEA	<input type="checkbox"/> microphthalmos <input type="checkbox"/> keratoconjunctivitis sicca <input type="checkbox"/> glaucoma	EYELIDS <input type="checkbox"/> entropion <input type="checkbox"/> ectropion	<input type="checkbox"/> distichiasis <input type="checkbox"/> ectopic cilia <input type="checkbox"/> imperforate lacrimal punctum NICTITANS <input type="checkbox"/> cartilage anomaly/eversion <input type="checkbox"/> gland prolapse <input type="checkbox"/> plasmoma/atypical pannus CORNEA <input type="checkbox"/> dystrophy — epithelial/stromal <input type="checkbox"/> dystrophy — endothelial <input type="checkbox"/> pannus <input type="checkbox"/> pigmentary keratitis/keratopathy UVEA <input type="checkbox"/> uveal cyst <input type="checkbox"/> iris coloboma <input type="checkbox"/> iris hypoplasia <input type="checkbox"/> iris sphincter dysplasia <input type="checkbox"/> pigmentary uveitis <input type="checkbox"/> uveal melanoma
endothelial opacity/no strands	<input type="checkbox"/> free floating <input type="checkbox"/> single <input type="checkbox"/> multiple	<input type="checkbox"/> persistent pupillary membranes	<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	<input type="checkbox"/> Incomp. <input type="checkbox"/> Incip. <input type="checkbox"/> Punc. <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	LENS <input type="checkbox"/> subluxation/luxation VITREOUS <input type="checkbox"/> PHPV/PHTVL <input type="checkbox"/> persistent hyaloid artery <input type="checkbox"/> degeneration	<input type="checkbox"/> syneresis <input type="checkbox"/> ant. chamber
Significance Unknown/Suspect Not Inherited	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

RIGHT EYE FUNDUS LEFT EYE

detached
 geographic
 folds
 retinal detachment
 retinal atrophy—generalized
 retinopathy
 retinal dysplasia

folds
 geographic
 detached

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 _____

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

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2/12/20