



# 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

Call Name:
Registered Name: <b>LITTLE MISS KARLIE</b>
Sex/Breed: <b>F GOLDENDOODLE</b>
Microchip/Tattoo: <b>990000001885303</b>
Registration No:
Date of Birth: <b>05/01/2016</b>
Owner Name: <b>ALVIN BRENNEMAN</b>
Co-owner Name:
Owner Address <b>5084 WEST 400 NORTH</b>
City/State/Postal: <b>PORTLAND IN 47371</b>
Email: <b>alvin.tina2@gmail.com</b>
Telephone: <b>260-438-8311</b>

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. **I 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

**09/29/2020**

Date of Exam (mm/dd/yyyy)

<input checked="" type="checkbox"/> I DID verify the microchip/tattoo on this dog.
<input type="checkbox"/> I DID NOT verify the microchip/tattoo on this dog.
<input type="checkbox"/> NO MICROCHIP/TATTOO PRESENT

I certify that I have performed this ophthalmological examination using pharmacological mydriasis, ophthalmoscopy, and biomicroscopy.

**DR. WENDY TOWNSEND 254 09/29/2020**

Signature/ACVO#/Date

Exam registration number: <b>20N7XE</b>

## Companion Animal Eye Registry (CAER)

RIGHT EYE		LEFT EYE	
CORNEA			
GLOBE			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
microphthalmos			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
keratoconjunctivitis sicca			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
glaucoma			
EYELIDS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
entropion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ectropion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
distichiasis			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ectopic cilia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
imperforate lacrimal punctum			
NICITANS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cartilage anomaly/eversion			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
gland prolapse			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
plasmoma/atypical pannus			
CORNEA			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dystrophy - epithelial/stromal			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
dystrophy - endothelial			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pannus			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pigmentary keratitis/keratopathy			
UVEA			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
uveal cyst			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iris coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iris hypoplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iris sphincter dysplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
pigmentary uveitis			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
uveal melanoma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
persistent pupillary membranes			
LENS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CATARACT			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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/incomplete			
<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"/>
Significance Unknown/Suspect Not Inherited			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
subluxation/luxation			
VITREOUS			
<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			

Ophthalmologist: <b>DR. WENDY TOWNSEND</b>
Clinic Name:
ACVO #: <b>254</b>
Phone:

RIGHT EYE		LEFT EYE	
FUNDUS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal detachment			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal atrophy - generalized			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinopathy			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
retinal dysplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
choroidal hypoplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
optic nerve coloboma			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
optic nerve hypoplasia			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
micropapillia			

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

<input checked="" type="checkbox"/>	<b>NORMAL</b>	<input checked="" type="checkbox"/>
-------------------------------------	---------------	-------------------------------------

Comments