



Orthopedic Foundation for Animals

2300 E Nifong Blvd, Columbia, MO 65201-3806

Phone: (573) 442-0418; Fax: (573) 875-5073

www.offa.org, A not-for-profit organization

Registered name: **CH. FRAKALIS MOVIN' ON UP**

Breed: **Labrador Retriever** Sex: **F**

ID Number (if any): Tattoo Microchip
0000004166748

Registration Number: AKC Other
SR73889905

Date of Birth: **07/10/12** Date of Exam: **03/06/16**

Owner/Co-owner Name: **Catherine Fisher**

Co-Owner Name: **Lisa Weiss** Phone: **518-222-9074**

Owner Address: **POB 204**

City: **Middle Granville** State: **NY** Zip/postal code: **12849**

E-Mail (use both lines if needed):
kakifisher@earthlink.net

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.

C Fisher

Signature of owner or authorized agent/representative

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.

Companion Animal Eye Registry (CAER)

RIGHT EYE		GLOBE	LEFT EYE	
<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"/>	
EYELIDS				
<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"/>	
NICTITANS				
<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"/>	
CORNEA				
<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"/>	exposure/pigmentary keratitis	<input type="checkbox"/>	<input type="checkbox"/>	
UVEA				
<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"/>	
<input type="checkbox"/>	persistent pupillary membranes	<input type="checkbox"/>	<input type="checkbox"/>	
LENS				
CATARACT		Incomp. Incip. Punc.	Punc. Incip. Incomp.	CATARACT
<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/complete	<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 of cataract unknown <input type="checkbox"/>				
<input type="checkbox"/> subluxation/luxation <input type="checkbox"/>				
VITREOUS				
<input type="checkbox"/>	PHPV/PTVL	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	degeneration	<input type="checkbox"/>	<input type="checkbox"/>	

Ophthalmologist Name: **Dr. Christa Corbett EC394**

Ophthalmologist Address: **Upstate Veterinary Specialties**

City: **Latham, NY** State: **NY** Zip/postal code: **12110**

Phone: **518-783-3198**

Email:

RIGHT EYE		FUNDUS	LEFT EYE	
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	retinopathy	<input type="checkbox"/>	<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"/>	
OTHER CONDITIONS				
<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"/>	

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: *Christa Corbett* ACVO # **394** Date: **3/6/16**

Diplomate, American College of Veterinary Ophthalmologists

Comments: