



# 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:	<b>INES</b>
Registered Name:	<b>SECRET HAVEN'S JEZABELLE HAWK CH.</b>
Sex/Breed:	<b>F BORZOI</b>
Microchip/Tattoo:	<b>990 000 001 209 850</b>
Registration No:	<b>JC4070462</b>
Date of Birth:	<b>02/26/2021</b>
Owner Name:	<b>MICHELE FINK</b>
Co-owner Name:	
Owner Address:	<b>10769 HULBERT RD</b>
City/State/Postal:	<b>BRINSTON ON K0E 1C0</b>
Email:	<b>fink.michele@yahoo.ca</b>
Telephone:	<b>613-315-3813</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

\_\_\_\_\_  
Date of Exam (mm/dd/yyyy)

<input 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 ophthalmic examination using pharmacological mydriasis, ophthalmoscopy, and biomicroscopy.*

\_\_\_\_\_  
Signature/ACVO#/Date

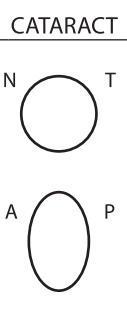
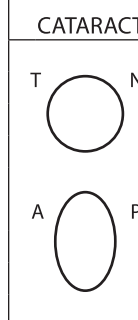
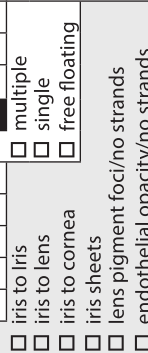
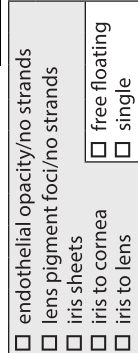
Exam registration number:



**24BX2H**

# Companion Animal Eye Registry (CAER)

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	keratoconjunctivitis sicca	<input type="checkbox"/>
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
<b>EYELIDS</b>		
<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"/>	imperforate lacrimal punctum	<input type="checkbox"/>
<b>NICTITANS</b>		
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>
<b>CORNEA</b>		
<input type="checkbox"/>	dystrophy — epithelial/stromal	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy — endothelial	<input type="checkbox"/>
<input type="checkbox"/>	pannus	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary keratitis/keratopathy	<input type="checkbox"/>
<b>UVEA</b>		
<input type="checkbox"/>	uveal cyst	<input type="checkbox"/>
<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
<input type="checkbox"/>	iris hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	iris sphincter dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>
<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>
<b>persistent pupillary membranes</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LENS</b>		
CATARACT		
<input type="checkbox"/>	Incomp. Incip. Punc.	<input type="checkbox"/>
<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/complete	<input type="checkbox"/>
<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>
<b>Significance Unknown/Suspect Not Inherited</b>		
<input type="checkbox"/>	posterior Y-suture tip opacities	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
<b>VITREOUS</b>		
<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>



Ophthalmologist: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

ACVO #: \_\_\_\_\_

Phone: \_\_\_\_\_

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>
<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>
<input type="checkbox"/>	CMR/CMR-like retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	other presumed inherited retinopathy	<input type="checkbox"/>
<b>retinal dysplasia</b>		
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	coloboma	<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"/>
<b>OTHER CONDITIONS</b>		
<input type="checkbox"/>	Unlisted conditions suspected as <b>inherited</b> . Describe in comments	<input type="checkbox"/>
<input type="checkbox"/>	Unlisted conditions suspected as <b>not inherited</b>	<input type="checkbox"/>
<b>NORMAL</b>		

Comments



# 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:	<b>INES</b>
Registered Name:	<b>SECRET HAVEN'S JEZABELLE HAWK CH.</b>
Sex/Breed:	<b>F BORZOI</b>
Microchip/Tattoo:	<b>990 000 001 209 850</b>
Registration No:	<b>JC4070462</b>
Date of Birth:	<b>02/26/2021</b>
Owner Name:	<b>MICHELE FINK</b>
Co-owner Name:	
Owner Address:	<b>10769 HULBERT RD</b>
City/State/Postal:	<b>BRINSTON ON K0E 1C0</b>
Email:	<b>fink.michele@yahoo.ca</b>
Telephone:	<b>613-315-3813</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

\_\_\_\_\_  
Date of Exam (mm/dd/yyyy)

<input 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 ophthalmic examination using pharmacological mydriasis, ophthalmoscopy, and biomicroscopy.*

\_\_\_\_\_  
Signature/ACVO#/Date

Exam registration number:



**24BX2H**

# Companion Animal Eye Registry (CAER)

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	keratoconjunctivitis sicca	<input type="checkbox"/>
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
<b>EYELIDS</b>		
<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"/>	imperforate lacrimal punctum	<input type="checkbox"/>
<b>NICTITANS</b>		
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>
<b>CORNEA</b>		
<input type="checkbox"/>	dystrophy — epithelial/stromal	<input type="checkbox"/>
<input type="checkbox"/>	dystrophy — endothelial	<input type="checkbox"/>
<input type="checkbox"/>	pannus	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary keratitis/keratopathy	<input type="checkbox"/>
<b>UVEA</b>		
<input type="checkbox"/>	uveal cyst	<input type="checkbox"/>
<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
<input type="checkbox"/>	iris hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	iris sphincter dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>
<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>
<b>persistent pupillary membranes</b>		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>LENS</b>		
CATARACT		
<input type="checkbox"/>	Incomp. Incip. Punc.	<input type="checkbox"/>
<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/complete	<input type="checkbox"/>
<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>
<b>Significance Unknown/Suspect Not Inherited</b>		
<input type="checkbox"/>	posterior Y-suture tip opacities	<input type="checkbox"/>
<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
<b>VITREOUS</b>		
<input type="checkbox"/>	PHPV/PHTVL	<input type="checkbox"/>
<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

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

Ophthalmologist:	<b>BERNHARD SPIESS</b>
Clinic Name:	
ACVO #:	<b>003</b>
Phone:	<b>613-329-7554</b>

RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>
<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>
<input type="checkbox"/>	CMR/CMR-like retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	other presumed inherited retinopathy	<input type="checkbox"/>
<b>retinal dysplasia</b>		
<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	coloboma	<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"/>
<b>OTHER CONDITIONS</b>		
<input type="checkbox"/>	Unlisted conditions suspected as <b>inherited</b> . Describe in comments	<input type="checkbox"/>
<input type="checkbox"/>	Unlisted conditions suspected as <b>not inherited</b>	<input type="checkbox"/>
<b>NORMAL</b>		

Comments