

OWNER **Bonnie Buckley** Phone **978-346-7248**  
 Animal Registered name **BONTON'S Aidan N' Abetting #098-D32-067**  
 Breed/Variety **Std. Poodle** Coat color/type **Brown** Permanent ID# **#098-D32-067**  
 MA 01860



203  
**Essex County Veterinary Referral Hospital**  
**Ruth M. Marrion, DVM, DACVO**  
**247 Chickering Rd.**  
**North Andover, MA 01845**  
**(978) 725-5544**

For litters, add number.

REGISTRATION NO.											
P	R	I	A	D	6	9	2	6	1		
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 *Bonnie Buckley*

**PRESS FIRMLY.**

**FILL COMPLETELY.**

**SEX**  
 Male  Female

**BIRTH DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY YEAR  
 13  08

**EXAM DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY YEAR  
 17  10

**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

506127  
 DO NOT MARK IN THIS AREA

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"/>	<b>OTHER UNLISTED CONDITIONS</b> suspected as inherited. Describe in comments.	<input type="checkbox"/>
<input type="checkbox"/>	<b>OTHER</b> conditions suspected as not inherited	<input type="checkbox"/>
<input type="checkbox"/>	<b>NORMAL</b>	<input type="checkbox"/>
<input type="checkbox"/>	<b>DUPLICATE FORM</b>	<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 *M. Marrion* Date *5/27/10*  
 Diplomate, American College of Veterinary Ophthalmologists

COMMENTS

ACVO #

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

Owner Copy