

OWNER **Bonnie Buckley** Phone **978-346-7248**
MERRIMACK, MA 01860
 Breed/Variety **Swiftwater's Fate Stepped IN Std. Poodle** Coat color/type **Blk + Apricot** Permanent ID#



203
Bulger Veterinary Hospital
Ruth M. Marrion, DVM, DACVO
247 Chickering Road
North Andover, MA 01845
(978) 725-5544

For litters, add number.

| REGISTRATION NO. | | | | | | | | | | | |
|------------------|---|---|---|---|---|---|---|---|---|---|---|
| 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
 22 11

EXAM DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
 DAY YEAR
 05 13

FOR CERF USE ONLY

| BREED | COLOR |
|-------|-------|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
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761937
 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"/> | EYELIDS | <input type="checkbox"/> |
| <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"/> | THIRD EYELID | <input type="checkbox"/> |
| <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"/> |
| <input type="checkbox"/> | CORNEA | <input type="checkbox"/> |
| <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"/> | exposure/pigmentary keratitis | <input type="checkbox"/> |
| <input type="checkbox"/> | UVEA | <input type="checkbox"/> |
| <input type="checkbox"/> | 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"/> |
| <input type="checkbox"/> | CATARACT | <input type="checkbox"/> |
| <input type="checkbox"/> | LENS | <input type="checkbox"/> |
| <input type="checkbox"/> | Diff. Inter. Punc. Punc. Inter. Diff. | <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 | <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"/> |
| <input type="checkbox"/> | VITREOUS | <input type="checkbox"/> |
| <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 dysplasia | <input type="checkbox"/> |
| <input type="checkbox"/> | 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"/> | OTHER UNLISTED CONDITIONS suspected as inherited. Describe in comments. | <input type="checkbox"/> |
| <input type="checkbox"/> | OTHER conditions suspected as not inherited | <input type="checkbox"/> |
| <input checked="" type="checkbox"/> | NORMAL | <input checked="" type="checkbox"/> |
| <input type="checkbox"/> | DUPLICATE FORM | <input type="checkbox"/> |
| <input type="checkbox"/> | This dog's microchip or tattoo has been verified/scanned and matches the (permanent ID) number provided on the form. | <input type="checkbox"/> |
| I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy. | | |
| Signature <i>Max</i> | | Date <i>8/8/13</i> |
| Diplomate, American College of Veterinary Ophthalmologists | | |
| COMMENTS | | |

ACVO # **242**

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