

OWNER **Bonnie Buckley** Phone **9783467248**
MERRIMAC MA 01860
 BREED/VARIETY **St. Poodle** Coat color/type **Brown Apricot** Permanent ID# **098-065-042**



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.											
7	8	1	1	3	4	9	5	0	7		
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
 1 2 3 4 5 6 7 8 9
 0 1 2 3 4 5 6 7 8 9
 1 4 0 8

EXAM DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
 DAY YEAR
 0 1 2 3 4 5 6 7 8 9
 0 1 2 3 4 5 6 7 8 9
 0 8 1 3

FOR CERF USE ONLY

BREED	COLOR
0 0 0	0 0 0
1 1 1	1 1 1
2 2 2	2 2 2
3 3 3	3 3 3
4 4 4	4 4 4
5 5 5	5 5 5
6 6 6	6 6 6
7 7 7	7 7 7
8 8 8	8 8 8
9 9 9	9 9 9

761940
 DO NOT MARK IN THIS AREA

RIGHT EYE	GLOBE	LEFT EYE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
<input type="checkbox"/>	dry eye	<input type="checkbox"/>
<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
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"/>
THIRD EYELID		
<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"/>
CORNEA		
<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"/>
UVEA		
<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"/>
CATARACT		
<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"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>
OTHER UNLISTED CONDITIONS suspected as inherited. Describe in comments.		
OTHER conditions suspected as not inherited		
NORMAL		
DUPLICATE FORM		
<input checked="" type="checkbox"/> This dog's microchip or tattoo has been verified/scanned and matches the (permanent ID) number provided on the form.		
I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.		
Signature <i>Ruth Marrion</i>		Date <i>8/8/13</i>
Diplomate, American College of Veterinary Ophthalmologists		
COMMENTS		
ACVO # <i>247</i>		

Please note to ensure proper registration this original owner's copy must be mailed directly to CERF