

OWNER **Bonnie Buckley** Phone **978 346 7248**  
**AK, MA 01860**  
 Animal Registered Name **Bon John's Shades of Whisperin**  
 Breed/Variety **Standard Poodle** Coat color/type **black & silver** Permanent ID# **098-069-627**



**CANINE EYE REGISTRATION FOUNDATION**

**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 *B. Buckley*

**PRESS FIRMLY. FILL COMPLETELY.**

**SEX**  
 Male  Female

**BIRTH DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY YEAR  
 14 07

**EXAM DATE**  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sep  Oct  Nov  Dec  
 DAY YEAR  
 28 11

**FOR CERF USE ONLY**

BREED	COLOR
A A A	0 0 0
B B B	1 1 1
C C C	2 2 2
D D D	3 3 3
E E E	4 4 4
F F F	5 5 5
G G G	6 6 6
H H H	7 7 7
I I I	8 8 8
J J J	9 9 9
K K K	
L L L	
M M M	
N N N	
O O O	
P P P	
Q Q Q	
R R R	
S S S	
T T T	
U U U	
V V V	
W W W	
X X X	
Y Y Y	
Z Z Z	

590175  
 DO NOT MARK IN THIS AREA

**CORNEA**

T N  
 A P

Endothelial opacity/no strands  
 Lens pigment foci/no strands  
 Iris Sheets  
 Iris to Cornea  
 Iris to Iris

**CATARACT**

T N  
 A P

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"/>	<b>EYELIDS</b>	<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"/>	eury/macro blepharon	<input type="checkbox"/>
<input type="checkbox"/>	<b>THIRD EYELID</b>	<input type="checkbox"/>
<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
<input type="checkbox"/>	<b>CORNEA</b>	<input type="checkbox"/>
<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"/>
<input type="checkbox"/>	<b>UVEA</b>	<input type="checkbox"/>
<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"/>
<input type="checkbox"/>	<b>LENS</b>	<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"/>	<b>VITREOUS</b>	<input type="checkbox"/>
<input type="checkbox"/>	PHPV/PTVL	<input type="checkbox"/>
<input type="checkbox"/>	degeneration	<input type="checkbox"/>

**CORNEA**

N T  
 A P

Iris to Iris  
 Iris to Lens  
 Iris to Cornea  
 Iris Sheets  
 Lens pigment foci/no strands  
 Endothelial opacity/no strands

**CATARACT**

N T  
 A P

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	<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"/>	<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 checked="" type="checkbox"/>

**DUPLICATE FORM**  
 This dog's microchip has been scanned and matches the number provided on the form.

I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.  
 Signature *R. M. De* Date *3/20/11*  
 Diplomate, American College of Veterinary Ophthalmologists

**COMMENTS**

ACVO #  
 292  
 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

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

Owner Copy