

OWNER: **Thad Lambert + Scott Rall** Phone: **507 360 6405**
 ADDRESS (Street & No., City, Zip Code): **29069 St Hwy 264 Round Lake Mn 56167**
 Animal Registered Name: **Round Lakes BEE'S TAKEN A CHANCE**
 Breed/Variety: **Labrador Retriever** Coat color/type: **Black** Permanent ID#:
 Sex: M F



CANINE EYE REGISTRATION FOUNDATION

"BJ"

100
 Stephen I. Bisner, DVM, DACVO
 4910 Saratoga Lane
 Plymouth, MN 55442
 (612) 382-0342
 bistr@comcast.net

For litters, add number.

REGISTRATION NO.											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signature: *Thad Lambert*

PRESS FIRMLY. FILL COMPLETELY.

SEX: Male Female

BIRTH DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

EXAM DATE
 Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

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.

FOR CERF USE ONLY

BREED: **LAB** COLOR: **B**

351670

DO NOT MARK IN THIS AREA

RIGHT EYE		GLOBE	LEFT EYE	
<input type="checkbox"/>	<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	dry eye	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
upper lower		EYELIDS	lower upper	
<input type="checkbox"/>	<input type="checkbox"/>	entropion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ectropion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	distichiasis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	ectopic cilia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	eury/macro blepharon	<input type="checkbox"/>	<input type="checkbox"/>
THIRD EYELID				
<input type="checkbox"/>	<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>	<input type="checkbox"/>
CORNEA				
<input type="checkbox"/>	<input type="checkbox"/>	dystrophy -- epithelial/stromal	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	dystrophy -- endothelial	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	inherited pannus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	exposure/pigmentary keratitis	<input type="checkbox"/>	<input type="checkbox"/>
UVEA				
<input type="checkbox"/>	<input type="checkbox"/>	iris/ciliary body cyst	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	iris hypoplasia/sphincter dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	uveal melanoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	persistent pupillary membranes	<input type="checkbox"/>	<input type="checkbox"/>
CATARACT				
<input type="checkbox"/>	<input type="checkbox"/>	Diff. Inter. Punc.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	anterior cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	posterior cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	equatorial cortex	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	anterior sutures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	posterior sutures	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	nucleus	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	capsular	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	generalized	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	significance of above cataract unknown (describe in comments)	<input type="checkbox"/>	<input type="checkbox"/>
<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"/>
<input type="checkbox"/>	<input type="checkbox"/>	degeneration	<input type="checkbox"/>	<input type="checkbox"/>

RIGHT EYE		FUNDUS	LEFT EYE	
<input type="checkbox"/>	<input type="checkbox"/>	retinal atrophy -- generalized	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal atrophy -- suspicious	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal dysplasia/retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	staphyloma/coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	micropapilla	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	OTHER UNLISTED CONDITIONS suspected as inherited. Describe in comments.	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	OTHER conditions suspected as not inherited	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	NORMAL	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	DUPLICATE FORM	<input type="checkbox"/>	<input type="checkbox"/>

I certify that I have performed this ophthalmic examination using pharmacologic mydriasis, ophthalmoscopy, and biomicroscopy.

Signature: *Stephen I. Bisner* Date: *3/8/07*

Diplomate, American College of Veterinary Ophthalmologists

COMMENTS

ACVO #

Owner Copy