

OWNER: David + Mitzi Day
 ADDRESS (Street & No., City, Zip Code): 1832 CR 2224 Caddo Mills, TX 75135
 Animal Registered Name: Day Dream Vogue
 Breed/Variety: Jack Russell Coat color/type: T/W Smooth Permanent ID#: 518434
 Phone: 903-527-3224



CANINE EYE REGISTRATION FOUNDATION

Art J. Quinn, DVM, DACVO
 210 Cedar Lane
 Diamond Head
 Sand Springs, OK 74063

REGISTRATION NO. [Grid of 0-9 digits]

Signature: *David Day*

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."

Signature: *David Day*

FOR CERF USE ONLY

BREED: [Grid of 0-9 digits]

COLOR: [Grid of 0-9 digits]

SEX: Male Female

BIRTH DATE: [Grid of 0-9 digits]

EXAM DATE: [Grid of 0-9 digits]

EXAM DATE: [Grid of 0-9 digits]

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"/>	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"/>	gland prolapse	<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"/>	inherited pannus	<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"/>	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 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"/>	OTHER UNLISTED CONDITIONS	<input type="checkbox"/>
<input type="checkbox"/>	suspected as inherited. Describe in comments.	<input type="checkbox"/>
<input type="checkbox"/>	OTHER conditions suspected as not inherited	<input type="checkbox"/>
<input type="checkbox"/>	NORMAL	<input 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: *A.J. Quinn* Date: *06-19-10*

Diplomate, American College of Veterinary Ophthalmologists

COMMENTS

ACVO # [Grid of 0-9 digits]

Owner Copy

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