

Call name:	Coco												
Registered name:	Miller's Coco xxiii												
Breed:	Poodle								Sex:	M			
ID Number (if any):	<input type="checkbox"/> Tattoo		<input checked="" type="checkbox"/> Microchip										
900115000308882													
Registration Number:	<input checked="" type="checkbox"/> AKC		<input type="checkbox"/> Other										
PR20288201													
Date of Birth (mm/dd/yy):	090117				Date of Exam (mm/dd/yy):				030124				
Owner Name:	Allen Miller												
Co-Owner Name:									Phone:	330-231-9802			
Owner Address:	1916 TR 122												
City:	Millersburg							State:	OH		Zip/postal code:	44654	
E-Mail (use both lines if needed):													




I hereby certify that the animal examined is the animal described on this application, and understand that the results of this exam will be submitted by the examining ophthalmologist to the database for statistical gathering purposes. I understand that only passing results will be released to the public unless the initials of a registered owner or authorized agent appear in the authorization box below which permits the OFA to release non-passing results to the public.

Signature of owner or authorized agent/representative

I hereby authorize the OFA to release the results of the evaluation of the animal described on this application to the public if the results are ~~non-passing~~ (initials) _____

<input checked="" type="checkbox"/>	I DID verify microchip/tattoo on this dog
<input type="checkbox"/>	I DID NOT verify microchip/tattoo on this dog
<input type="checkbox"/>	NO MICROCHIP/TATTOO PRESENT

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

Signature 	ACVO # 	Date 
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Diplomate, American College of Veterinary Ophthalmologists

FEES AND CREDIT CARD INFORMATION ON THE BACK OF THE WHITE (OWNER) COPY



873497

Companion Animal Eye Registry (CAER)

RIGHT EYE		GLOBE	LEFT EYE	
		<input type="checkbox"/> microphthalmos		
		<input type="checkbox"/> keratoconjunctivitis sicca		
		<input type="checkbox"/> glaucoma		
		EYELIDS		
		<input type="checkbox"/> entropion		
		<input type="checkbox"/> ectropion		
		<input type="checkbox"/> distichiasis		
		<input type="checkbox"/> ectopic cilia		
		<input type="checkbox"/> imperforate lacrimal punctum		
		NICTITANS		
		<input type="checkbox"/> cartilage anomaly/eversion		
		<input type="checkbox"/> gland prolapse		
		<input type="checkbox"/> plasmoma/atypical pannus		
		CORNEA		
		<input type="checkbox"/> dystrophy — epithelial/stromal		
		<input type="checkbox"/> dystrophy — endothelial		
		<input type="checkbox"/> pannus		
		<input type="checkbox"/> pigmentary keratitis/keratopathy		
		UVEA		
		<input type="checkbox"/> uveal cyst		
		<input type="checkbox"/> iris coloboma		
		<input type="checkbox"/> iris hypoplasia		
		<input type="checkbox"/> iris sphincter dysplasia		
		<input type="checkbox"/> pigmentary uveitis		
		persistent pupillary membranes		
		LENS		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> anterior cortex		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> posterior cortex		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> equatorial cortex		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> anterior sutures		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> posterior sutures		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> nucleus		
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> capsular		
		<input type="checkbox"/> generalized/complete		
		<input type="checkbox"/> resorbing/hypermature		
		<input type="checkbox"/> Significance Unknown/Suspect Not Inherited		
		<input type="checkbox"/> posterior Y-suture tip opacities		
		<input type="checkbox"/> subluxation/luxation		
		VITREOUS		
		<input type="checkbox"/> PHPV/PHTVL		
		<input type="checkbox"/> persistent hyaloid artery		
		degeneration		

Ophthalmologist Name:

Adam King, DVM, DACVO
EC555

Ophthalmologist Address:

askingdvm@gmail.com

City:

State:

Zip/postal code:

Phone:

ACVO #:

Email:

RIGHT EYE		FUNDUS	LEFT EYE	
<input type="checkbox"/>	detached	<input type="checkbox"/> retinal detachment	<input type="checkbox"/>	
<input type="checkbox"/>	geographic	<input type="checkbox"/> retinal atrophy— generalized	<input type="checkbox"/>	
<input type="checkbox"/>	folds	<input type="checkbox"/> CMR/CMR-like retinopathy	<input type="checkbox"/>	
		<input type="checkbox"/> other presumed inherited retinopathy		
		retinal dysplasia	<input type="checkbox"/>	folds
		<input type="checkbox"/> choroidal hypoplasia	<input type="checkbox"/>	
		<input type="checkbox"/> coloboma	<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 CONDITIONS				
<input type="checkbox"/>	Unlisted conditions suspected as inherited . Describe in comments	<input type="checkbox"/>		
<input type="checkbox"/>	Unlisted conditions suspected as not inherited	<input type="checkbox"/>		
<input checked="" type="checkbox"/>	NORMAL			<input checked="" type="checkbox"/>

Comments

[illegible]

11/18/21

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WHITE = Owner/OFA Registration copy; PINK = ACVO Diplomate copy; YELLOW = ACVO Research copy



Orthopedic Foundation for Animals

2300 E Nifong Blvd, Columbia, MO 65201-3806

Phone: (573) 442-0418; Fax: (573)875-5073

www.ofa.org, A not-for-profit organization

Application for Advanced Cardiac Database

Performed in association with the Orthopedic Foundation for Animals (OFA)
and the American College of Veterinary Internal Medicine-Cardiology (ACVIM)



Registered name: <u>Miller's Coco</u>	
Call name: <u>Coco</u>	Weight: <input type="checkbox"/> kg <input checked="" type="checkbox"/> lbs <u>16</u> Estimate
Breed: <u>Poodle</u>	Gender: <u>M</u>
Sire Registration #: <u>PR17568907</u>	Dam Registration #: <u>PR17665501</u>
ID Number (if any): <input type="checkbox"/> Tattoo <input checked="" type="checkbox"/> Microchip	
<u>900115000308882</u>	
Registration Number: <input checked="" type="checkbox"/> AKC <input type="checkbox"/> Other	
<u>PR20288201</u>	
Date of Birth: (MMDDYY) <u>090117</u>	Date of Exam: (MMDDYY)
Owner Name: <u>Allen Miller</u>	
Co-Owner Name:	Phone: <u>330-674-6679</u>
Owner Address: <u>1916 TR 122</u>	
City: <u>Millersburg</u>	State: <u>OH</u> Zip/postal code: <u>44654</u>
E-Mail (use both lines if needed):	

I hereby certify that the animal examined is the animal described on this application, and understand that the results of this exam will be submitted by the examining cardiologist to the database for statistical gathering purposes. I understand that only passing results will be released to the public unless the initials of a registered owner or authorized agent appear in the authorization box below which permits the OFA to release non-passing results to the public.

Signature of owner or authorized agent/representative

I hereby authorize the OFA to release equivocal or abnormal results to the public. (initials) _____

Megan McLane, DVM DACVIM (Cardiology)

CM07

Care Center Cincinnati

513-530-0911

cardiology@carecentervets.com

Fees and credit card information on back of WHITE sheet.

12/22/15



C112410

Genetic Test Status: Test	
Negative <input type="checkbox"/> Abnormal: Heterozygous <input type="checkbox"/> Homozygous <input type="checkbox"/>	
EXAMINATION FINDINGS	
AUSCULTATION	
Normal <input checked="" type="checkbox"/> Abnormal <input type="checkbox"/> Arrhythmia <input type="checkbox"/>	
Murmur Grade: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> V <input type="checkbox"/> VI <input type="checkbox"/>	
PMI: Left <input type="checkbox"/> Right <input type="checkbox"/> Base <input type="checkbox"/> Apex <input type="checkbox"/>	
Timing: Systolic <input type="checkbox"/> Diastolic <input type="checkbox"/> Continuous <input type="checkbox"/>	
Extra Sounds: Click <input type="checkbox"/> Gallop <input type="checkbox"/> Split S1 <input type="checkbox"/> Split S2 <input type="checkbox"/>	
ECHOCARDIOGRAM <input type="checkbox"/> NOT PERFORMED	
RA: Normal <input type="checkbox"/> Enlarged _____ mm	RV: Normal <input type="checkbox"/> enlarged _____ mm
TV: Normal <input type="checkbox"/> Abnormal: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
TR: None <input type="checkbox"/> Trivial <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Vel. _____ m/s	
LA: Normal <input type="checkbox"/> Enlarged: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
LAd _____ mm: SAx <input type="checkbox"/> LAx <input type="checkbox"/> (MM <input type="checkbox"/> 2D <input type="checkbox"/>)	
MV: Normal <input type="checkbox"/> Abnormal: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
MR: None <input type="checkbox"/> Trivial <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Vel. _____ m/s	
LV: Normal <input type="checkbox"/> Enlarged: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
LVIDd: _____ mm MM <input type="checkbox"/> 2D <input type="checkbox"/> LVIDs: _____ mm MM <input type="checkbox"/> 2D <input type="checkbox"/>	
SF: _____ % (MM <input type="checkbox"/> 2D <input type="checkbox"/>) EF: _____ % (MM <input type="checkbox"/> 2D <input type="checkbox"/> volumetric)	
ESVI: _____ mL/m ² Sphericity Index _____ EPSS: _____ mm	
IVS: IVSd _____ mm Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> (MM <input type="checkbox"/> 2D <input type="checkbox"/>)	
PW: PWd _____ mm Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> (MM <input type="checkbox"/> 2D <input type="checkbox"/>)	
PapMuscle: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/>	
LVOT Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Ridge <input type="checkbox"/> Other _____	
AoV: Normal <input type="checkbox"/> Abnormal: Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
Ao Diameter: _____ mm LA/Ao: _____ Method: _____	
AoV/LVOT Vel: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> (Apical <input type="checkbox"/> Subcostal <input type="checkbox"/>) _____ m/s	
DLVOTO: <input type="checkbox"/> Vmax _____ m/s SAM: <input type="checkbox"/>	
AR: None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> _____ m/s	
RVOT: Normal <input type="checkbox"/> Infundibular narrowing <input type="checkbox"/> Vmax (if abnormal) _____ m/s	
DRVOTO: <input type="checkbox"/> Vmax _____ m/s	
PV: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
PV Vel: Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> (Right <input type="checkbox"/> Left apex <input type="checkbox"/>) _____ m/s	

ELECTROCARDIOGRAM (ECG)	
<input type="checkbox"/> normal <input type="checkbox"/> abnormal <input type="checkbox"/> not performed	
Date: _____	Method: _____
HR: _____ bpm	Rhythm: _____
HOLTER ECG	
Date performed: _____ <input type="checkbox"/> pending <input type="checkbox"/> not performed	
normal: <input type="checkbox"/> equivocal: <input type="checkbox"/> abnormal: <input type="checkbox"/> (see Holter report for details)	
EXAMINATION RESULTS	
<input checked="" type="checkbox"/> NORMAL	
<input checked="" type="checkbox"/> No evidence for congenital heart disease	
<input checked="" type="checkbox"/> No evidence for adult onset inherited heart disease	
<input checked="" type="checkbox"/> Valid for 1 year (In Dobermans and Boxers preliminary clearance only. Holter required within 3 months of today for final clearance)	
<input type="checkbox"/> EQUIVOCAL	
<input type="checkbox"/> Congenital or adult onset inherited heart disease cannot be definitively diagnosed or excluded	
<input type="checkbox"/> ABNORMAL	
(evidence of congenital or adult onset inherited heart disease)	
Diagnosis:	<input type="checkbox"/> ARVC <input type="checkbox"/> ASD <input type="checkbox"/> DCM <input type="checkbox"/> HCM <input type="checkbox"/> MVD <input type="checkbox"/> MMVD <input type="checkbox"/> PDA <input type="checkbox"/> PS <input type="checkbox"/> SAS/AS <input type="checkbox"/> TVD <input type="checkbox"/> VSD <input type="checkbox"/> Other _____
Severity:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Comments (additional findings which would not result in a final abnormal diagnosis): _____ _____ _____	

<input checked="" type="checkbox"/>	I DID verify microchip/tattoo on this dog
<input type="checkbox"/>	I DID NOT verify microchip/tattoo on this dog
<input type="checkbox"/>	NO MICROCHIP/TATTOO PRESENT

Signature _____	Date <u>11/26/2020</u>
Diplomate ACVIM (American College of Veterinary Internal Medicine - Cardiology), or Diplomate ECVIM (European College of Veterinary Internal Medicine - Cardiology)	