

**Manitoba Animal Eye Clinic
mbeyeclinic@gmail.com**

Dr. Bruce Grahn, DVM
Dr. Lynne Sandmeyer, DVM
Dr. Bianca Bauer, DVM

Location

Bridgwater Veterinary Hospital & Wellness Centre
100-350 North Town Road, Winnipeg

Dates

**Saturday and Sunday
July 7/8, 2018**

**Friday and Saturday
August 24/25, 2018**

**Saturday and Sunday
October 13/14, 2018**

Services Offered

Clinical exams \$200
Recheck eye exams \$160
OFA/CERF \$40 first exam/\$35 each additional exam
Eye exam for horses available at an additional fee

**PLEASE NOTE: BRIDGWATER VETERINARY HOSPITAL IS NOT
AFFILIATED WITH THE ANIMAL EYE CLINIC. PLEASE CONTINUE TO
CONTACT CATHY AND CHERYL AT mbeyeclinic@gmail.com FOR
ANY QUESTIONS OR APPOINTMENTS.**

REGISTRATION PROCESS

The quickest way to register is to email completed registration forms to us and pay by online e-transfer, to mbeyeclinic@gmail.com. You can also mail your forms with a check or money order made payable to Animal Eye Clinic Manitoba. Mailing address is 4 Lakemere Pl, Wpg, MB, R2J 2T6 Attn: Cathy Fedick.

PLEASE NOTE: DUE TO A LARGE VOLUME OF LAST MINUTE CANCELLATIONS AND NO SHOWS, IT IS NOW OUR POLICY TO HAVE RECEIVED A REGISTRATION FORM AND PAYMENT BEFORE AN APPOINTMENT IS GIVEN.

LOCATION

Bridgwater Veterinary Hospital
100-350 North Town Road, Winnipeg
South of the new Bishop Grandin overpass
Located at the corner of North bound Kenaston and North Town Road

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REGISTRATION FORM

Owner: _____
Address: _____
City: _____ Province: _____
Phone: _____ Postal Code: _____
Email: _____

Please select one:

() \$200 Clinical Exam () \$40 OFA/CERF (first dog)
() \$160 Recheck Exam () \$35 OFA/CERF (each add'l dog)
Month? _____ Sat or Sun (circle one)

Patient Information:

Pets name: _____
Breed: _____
Date of Birth: _____ Sex: male, female, spay, neuter
Veterinarian's name: _____
Veterinarian's clinic: _____

Has your pet been previously seen by Drs. Grahn, Sandmeyer or Bauer?
Yes or no

If this is for an OFA/CERF exam please fill out the following:

Registered name: _____
CKC Registration: _____
Tattoo/microchip #: _____

MEDICAL HISTORY

Owner Name _____ Pet Name _____

What is the problem(s): _____

When was eye problem first noticed? _____

Have you noticed vision loss? Yes or no When? _____

Current Diagnosis? _____

Current Medications (name, how often given, which eye(s))

Has any surgery been performed on the eye(s)? Yes or No

Name/type of surgery and when _____

Please list all non-ocular (non-eye related) medical conditions:

Please list all non-ocular medications:
