Animal Eye Clinic Manitoba

mbeyeclinic@gmail.com

Dr. Bruce Grahn, DVM

LOCATION

Bridgwater Veterinary Hospital & Wellness Centre

100-350 North Town Rd, Winnipeg

PLEASE NOTE: THE ANIMAL EYE CLINIC IS NOT AFFILIATED WITH BRIDGWATER VET. IF YOU HAVE ANY QUESTIONS REGARDING THE EYE CLINIC PLEASE EMAIL US AT mbeyeclinic@gmail.com. DO NOT CALL/FAX/EMAIL OR MAIL TO BRIDGWATER VET. THEY HAVE NO ACCESS TO OUR FILES OR APPOINTMENTS .

UPCOMING CLINIC DATES

APRIL 28-30TH, 2022

JUNE 2-4TH, 2022

JULY 7-9TH, 2022

AUGUST 18-20TH, 2022

SEPTEMBER 22-24TH, 2022

SERVICES OFFERED

OUR FEES HAVE INCREASED AS OF FEBRUARY 2022

CLINICAL/PRIMARY EXAMS (NEW CLIENT TO US)...........$250

RECHECK EXAMS (HAVE SEEN THE OPHTHALMOLOGIST BEFORE)..........$210

OFA/CERF.......$45 FIRST DOG........$40 EACH ADDITIONAL DOG BROUGHT AT THE SAME TIME

HORSES AVAILABLE AT AN ADDITIONAL FEE

REGISTRATION PROCESS

The quickest way to register is to email your completed registration form and pay by online etransfer, to mbeyeclinic@gmail.com. You can also mail your forms with a cheque made payable to Animal Eye Clinic Manitoba. Mailing address is 4 Lakemere Pl, Wpg, MB R2J 2T6 attn: Cathy Fedick. Sorry we do not accept debit or credit card payments.

If you are a referring clinic submitting the form for your client, please also notify your client to send us an email so we can co-ordinate an appointment with them

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.

REGISTRATION FORM

(please fill in all the blanks)

Owner:____

Address:____

City:__________________________Province:______________________

Phone:_________________________Postal Code:___________________

Email Address:____

Please select one:

( )$250 Clinical Exam ( )$45 OFA/CERF (first dog)

( )$210 Recheck Exam ( )$40 OFA/CERF (each add'l dog)

Month and day requested:__________________________________

Patient Information:

Pets name:____________________Breed__________________________

Date of Birth:___________________Sex: Male,Neutered,Female,Spayed

Veterinarian's name:____

Veterinarian clinic____

Has your pet been previously seen by Drs. Grahn, Sandmeyer, or Leis?

Yes or No

If this is for an OFA/CERF (breeding certification) exam please fill out the following:

Registered name:____

CKC Registration:____

Tattoo/microchip #:____

MEDICAL HISTORY

Owner name:____________________________________ **Pet Name**:_______________________

What is/are 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))

PLEASE BRING ALL MEDICATIONS WITH YOU TO YOUR APPOINTMENT

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

If yes, what kind____

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

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