

# Animal Eye Clinic Manitoba

[mbeyeclinic@gmail.com](mailto:mbeyeclinic@gmail.com)

Dr. Bruce Grahm, DVM

Dr. Lynne Sandmeyer, DVM

Dr. Bianca Bauer, 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](mailto:mbeyeclinic@gmail.com). DO NOT CALL/FAX/EMAIL OR MAIL TO BRIDGWATER VET. THEY HAVE NO ACCESS TO OUR FILES OR APPOINTMENTS .**

## DATES

AUGUST 16 /17, 2019 (Friday & Saturday)

SEPT 21/22, 2019 (Saturday & Sunday)

OCT 18/19 (Friday & Saturday)

Nov 23/24 (Saturday & Sunday)

## SERVICES OFFERED

CLINICAL EXAMS \$210

RECHECK EXAMS (HAVE SEEN THE OPHTHALMOLOGIST BEFORE) \$170

OFA/CERF \$40 FIRST EXAM/\$35 EACH ADDITIONAL EXAM

HORSES AVAILABLE AT AN ADDITIONAL FEE

**PLEASE NOTE OUR FEES FOR OUR CLINICAL & RECHECK EXAMS HAVE INCREASED**

## **REGISTRATION PROCESS**

The quickest way to register is to email your completed registration form and pay by online etransfer, to [mbeyeclinic@gmail.com](mailto:mbeyeclinic@gmail.com). You can also mail your forms with a cheque 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

## REGISTRATION FORM

Owner: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_  
Phone: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Email: \_\_\_\_\_

**Please select one:**

( ) \$210 Clinical Exam ( ) \$40 OFA/CERF (first dog)  
( ) \$170 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))

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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:

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Please list all non-ocular medications:

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