

ORTHOPEDIC FOUNDATION FOR ANIMALS, INC.

MAPLE GROVE REX
registered name

POODLE, MINIATURE
breed

film/test/lab #

900233004095365
tattoo/microchip/DNA profile

2615676
application number

03/02/2026
date of report

RESULTS:

The results of the examination submitted to OFA indicate that no evidence of patellar luxation was recognized.

owner
ALLEN MILLER
1916 TR 122
MILLERSBURG OH 44654

OFA eCert



Verify QR scan

PR28202702
registration no.

M
sex

02/28/2024
date of birth

17
age at evaluation in months



A Not-For-Profit Organization

PO-PA14295/17M/P-VPI
O.F.A. NUMBER

This number issued with the right to correct or revoke by the Orthopedic Foundation for Animals.

NORMAL - PRACTITIONER

G.G. KELLER, DVM, MS, DACVR
CHIEF OF VETERINARY SERVICES

www.ofa.org

This electronic OFA certificate was generated on: 03/02/2026

This certification can be verified on the OFA website by entering the animal's registration number into the orange search box located at the top of the page or by scanning the QR code above.

If there are any errors on this certificate, please email CORRECTIONS@OFA.ORG to request a correction.

Orthopedic Foundation for Animals, Inc.
2300 E. Nifong Blvd.
Columbia, MO 65201-3806

OFA website: www.ofa.org
E-mail address: ofa@ofa.org
Phone number: 573-442-0418
Fax number: 573-875-5073



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

Call name: Rex	Coat Color: Red
Registered name: Maple Grove Rex	
Breed: Mini Poodle	Sex: M
ID Number (if any): <input type="checkbox"/> Tattoo <input checked="" type="checkbox"/> Microchip	
900233004095365	
Registration Number: <input checked="" type="checkbox"/> AKC <input type="checkbox"/> Other	
PR28202702	
Date of Birth (mm/dd/yy): 022824	Date of Exam (mm/dd/yy): 030325
Owner Name: Allen Miller	
Co-Owner Name:	Phone: 330-23-9802
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: **[Signature]** ACVO # **534** Date **3/3/25**

Diplomate, American College of Veterinary Ophthalmologists

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

Companion Animal Eye Registry (CAER)

	RIGHT EYE	GLOBE	LEFT EYE
	<input type="checkbox"/>	microphthalmos	<input type="checkbox"/>
	<input type="checkbox"/>	keratoconjunctivitis sicca	<input type="checkbox"/>
	<input type="checkbox"/>	glaucoma	<input type="checkbox"/>
	EYELIDS		
	<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"/>	imperforate lacrimal punctum	<input type="checkbox"/>
	NICTITANS		
	<input type="checkbox"/>	cartilage anomaly/eversion	<input type="checkbox"/>
	<input type="checkbox"/>	gland prolapse	<input type="checkbox"/>
	<input type="checkbox"/>	plasmoma/atypical pannus	<input type="checkbox"/>
	CORNEA		
	<input type="checkbox"/>	dystrophy — epithelial/stromal	<input type="checkbox"/>
	<input type="checkbox"/>	dystrophy — endothelial	<input type="checkbox"/>
	<input type="checkbox"/>	pannus	<input type="checkbox"/>
	<input type="checkbox"/>	pigmentary keratitis/keratopathy	<input type="checkbox"/>
	UVEA		
	<input type="checkbox"/>	uveal cyst	<input type="checkbox"/>
	<input type="checkbox"/>	iris coloboma	<input type="checkbox"/>
	<input type="checkbox"/>	iris hypoplasia	<input type="checkbox"/>
	<input type="checkbox"/>	pigmentary uveitis	<input type="checkbox"/>
	peristent pupillary membranes		
	LENS		
	<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/complete	<input type="checkbox"/>
	<input type="checkbox"/>	resorbing/hypermature	<input type="checkbox"/>
	Significance Unknown/Suspect Not Inherited		
	<input type="checkbox"/>	posterior Y-suture tip opacities	<input type="checkbox"/>
	<input type="checkbox"/>	subluxation/luxation	<input type="checkbox"/>
	VITREOUS		
	<input type="checkbox"/>	Grades 2-6	<input type="checkbox"/>
	<input type="checkbox"/>	Grade 1 PHPV/PHTVL	<input type="checkbox"/>
	<input type="checkbox"/>	Grades 2-6	<input type="checkbox"/>
	<input type="checkbox"/>	persistent hyaloid artery	<input type="checkbox"/>
	degeneration		

Ophthalmologist Name: _____

Ophthalmologist Address: **Dr. Eric J Miller**

City: **EC 534** State: _____ Zip/postal code: _____

Phone: _____

Email: _____

	RIGHT EYE	FUNDUS	LEFT EYE
<input type="checkbox"/>	<input type="checkbox"/>	retinal detachment	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal atrophy—generalized	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	CMR/CMR-like retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	other presumed inherited retinopathy	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	retinal dysplasia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	choroidal hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	coloboma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve coloboma	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	optic nerve hypoplasia	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	micropapilla	<input type="checkbox"/>

OTHER CONDITIONS

Unlisted conditions suspected as **inherited**. Describe in comments

Unlisted conditions suspected as **not inherited**

NORMAL

Comments



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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)



American College of Veterinary Internal Medicine

Registered name: **Maple Grove Rex**

Call name: **Rex** Weight: kg lbs
 Estimate

Breed: **Poodle** Gender: **M**

Sire Registration #: **PR26542403** Dam Registration #: **PR25279602**

Registration Number: AKC Other
PR2820702

ID Number (if any): Tattoo Microchip
9002330044095365

Date of Birth: (MMDDYY) **022824** Date of Exam: (MMDDYY) **082125**

Owner Name: **Allen Miller**

Co-Owner Name: _____ Phone: **330-231-9802**

Owner Address: **1916 112 122**

City: **Millersburg** State: _____ Zip/postal code: **0114654**

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) _____

C Megan McLane, DVM DACVIM
P Cardiology - CM07
E 513-530-0911
cardiology@carecentervets.com

Fees and credit card information on back of WHITE sheet.
03/01/2023



182710

EXAMINATION FINDINGS

AUSCULTATION (REQUIRED)

Normal Abnormal Arrhythmia

Murmur Grade: I II III IV V VI

PMI: Left Right Base Apex

Timing: Systolic Diastolic Continuous

Extra Sounds: Click Gallop Split S1 Split S2

ECHOCARDIOGRAM (REQUIRED)

RV: Normal Enlarged: Mild Moderate Severe _____ mm

RA: Normal Enlarged: Mild Moderate Severe _____ mm

LV: Normal Enlarged: Mild Moderate Severe

LVIDd: _____ mm LVIDdn: _____ mm (MM 2D

LVIDs: _____ mm LVIDsn: _____ mm (MM 2D

LV EDVI (2D): _____ mL/m² LV ESVI (2D): _____ mL/m²

SF: _____ % (MM 2D EF (2D volumetric): _____ %

IVS: IVSd _____ mm Normal Abnormal (MM 2D

PW: PWd _____ mm Normal Abnormal (MM 2D

LA: Normal Enlarged: Mild Moderate Severe

LAd: _____ mm: SAx LAx (MM 2D EPSS: _____ mm

Ao Diameter: _____ mm LA/Ao: _____ Method: _____

TV: Normal Abnormal: Mild Moderate Severe

TR: None Trivial Mild Moderate Severe Vel. _____ m/s

MV: Normal Abnormal: Mild Moderate Severe

MR: None Trivial Mild Moderate Severe Vel. _____ m/s

LVOT: Normal Abnormal Ridge Other _____

LVOT Vel: Normal Abnormal _____ m/s

AoV: Normal Abnormal: Mild Moderate Severe

AoV Vel: Normal Abnormal (Apical Subcostal) _____ m/s

AR: None Trivial Mild Moderate Severe _____ m/s

RVOT: Normal Infundibular narrowing Vmax (if abnormal) _____ m/s

RVOT Vel: Normal Abnormal _____ m/s

PV: Normal Abnormal Mild Moderate Severe

PV Vel: Normal Abnormal (Right Left apex) _____ m/s

Comments _____

Genetic Test Status Test: _____
Negative Abnormal: Heterozygous Homozygous

ELECTROCARDIOGRAM NOT PERFORMED

Date: _____ normal abnormal

HR: _____ Method: _____

Rhythm: _____

EXAMINATION RESULTS

NORMAL (CHECK ALL THAT APPLY)

No evidence for congenital heart disease

No evidence for adult-onset inherited heart disease
Valid for 1 year

Holter monitor required within 90 days for final clearance (see back of white form for additional information)

EQUIVOCAL (CHECK ALL THAT APPLY)

Congenital heart disease cannot be definitively diagnosed nor excluded

Adult-onset inherited heart disease cannot be definitively diagnosed nor excluded

ABNORMAL (CHECK ALL THAT APPLY)

Evidence of congenital heart disease

Evidence of adult-onset inherited heart disease

Diagnosis: ARVC ASD DCM MVD MMVD
 PDA PS SAS/AS TVD VSD
 Other
 Arrhythmia

Severity: Mild Moderate Severe

Comments (additional findings which would not result in a final abnormal diagnosis): _____

I DID verify microchip/tattoo on this dog

I DID NOT verify microchip/tattoo on this dog

NO MICROCHIP/TATTOO PRESENT

Signature: _____ Date: **8/21/05**

Diplomate ACVIM (American College of Veterinary Internal Medicine - Cardiology), or Diplomate ECVIM (European College of Veterinary Internal Medicine - Cardiology)

WHITE = Owner/OFA Registration copy
PINK = Diplomate copy
YELLOW = Research copy © Orthopedic Foundation for Animals