

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

SEPTEMBER 22-24TH, 2022

OCTOBER 20-22ND, 2022

NOVEMBER 17-19TH, 2022

DECEMBER 15-17TH, 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 e-transfer, 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

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:
