



2016 ALL BREED HEALTH CLINIC

**SUNDAY
MAY 22, 2016
8am - 4pm***

Suffield Veterinary
Hospital
577 East St South
(Route 159)
Suffield, CT 06078

FMI/Questions: www.CRVGRC.org

Cathy Guglielmo
413.734.1510
WoodwindGR@comcast.net

Christine Valls
CaledoniaGoldens@aol.com

Registration Confirmations
and exam times will be
emailed during the week
prior to the clinic. The email
will come from
CaledoniaGoldens@aol.com.
Please check your spam
folder.

*Clinic will end at 4pm or at the
completion of all scheduled
appointments

Eye Exams:

Dr. Charles M. Stuhr, DVM, ACVO

Fee \$30

- Minimum age for examination is eight weeks.
- Arrive 15 minutes prior to exam time to have eye drops administered and forms filled out.
- AKC registration & permanent identification is required for OFA.

Heart Exams:

Dr. Nancy Morris DVM, ACVIM in Cardiology

Auscultation Fee \$40

Doppler Echo Fee \$200

- Doppler Echo Fee includes Auscultation.
- **MUST PREREGISTER AT:** www.massvetcardiology.com
- Registration must be also be sent to CRVGRC per attached form
- Payment should be sent to CRVGRC, **NOT** thru massvetcardiology.com

XRAYS - Hips & Elbows:

Dr. Ann Huntington, DVM

Fee \$225

- Limited to 15 dogs.
- Goldens will get preference.
- Contact us for weight restrictions before registering your large breed dog.
- A completed OFA Form MUST accompany this application. OFA Fee paid separately. Forms can be found at http://www.ofa.org/pdf/hdedapp_bw.pdf

Microchip:

Dr. Dawn Burke

Fee \$40

Broad Institute & CHIC DNA Collection:

No Charge

- Please bring your dog's AKC number, litter number OR pedigree (if not AKC Registered) and health information including any prior clearances

Directions to SVH:

From I-91: Take Exit 47 East/West for Route 190 West to Suffield. Route 190 crosses the CT River and at the lights take a left onto Route 159 South. The Suffield Veterinary Hospital is about 2 miles on the right.

CONNECTICUT RIVER VALLEY GOLDEN RETRIEVER CLUB

2016 HEALTH CLINIC – MAY 22, 2016

PRE-REGISTRATION ONLY

DEADLINE: Friday, May 13, 2016

Name: _____ Home# _____ Cell# _____

Address: _____

Email: _____

(Please write clearly, registration confirmation and exam times will be emailed out the week of the clinic)

Preferred Time(s) : _____ 8-10 AM _____ 10-12 PM _____ 12-2 PM _____ 2-4 PM*

If no preference, check all. We will do our best to accommodate preferred timeslots.

NOTE: Due to the number of Exams requested, we may not schedule any exams between 2-4PM.

Put an "X" under each exam requested. Please list each dog separately. (see example)

Dog Call Name	Breed	Eye	Heart Auscl.	Heart Echo	XRAY	Chip	DNA
<i>Fido</i>	<i>Golden</i>	<i>X</i>		<i>X</i>		<i>X</i>	<i>X</i>
Total Exams Requested							
Unit Cost		x \$30	x \$40	x \$200	x \$225	x \$40	No Charge
= Amt.							\$0

(*sum of all columns)

SEND THIS FORM WITH CHECK PAYABLE TO CRVGRC

CATHY GUGLIELMO, 254 UPPER VIRGINIA AVE., WEST SPRINGFIELD, MA 01089

All Fees are Non-Refundable