



Endoscopic Examination

Please enter requested information and send this form and **VIDEO TAPE** to address below.

PLEASE INCLUDE AT LEAST TWO MINUTES OF DIRECT OBSERVATION

OF LARYNGEAL MOVEMENT

Horse Name: _____ Date of Procedure: _____

Registration Number: _____ Location of Procedure: _____

Clinician Name: _____

Owner Name: _____

Signature: _____

Area Examined:

Nasal passages: _____ Epiglottis*: _____

Ethmoid Area: _____ Arytenoids*: _____

Pharynx*: _____ Ventricles*: _____

G.P. Openings: _____ Trachea: _____

Soft Palate: _____ Guttural Pouches: _____

Endoscopic Report:

*Mark Lesions

Comments:



Return form and video/CD to:

KWPN of North America, KWPN-NA
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Lexington, KY 40511

Phone: 859-225-5331 ❖ Fax: 859-455-7457 ❖ E-mail: office@kwpn-na.org