



Antelope Valley
Medical Center

SURGERY SCHEDULING FORM

AVMC Scheduling Phone #:

(661) 949-5315

Fax ALL Preadmission Information Paperwork to:

(661) 206-6223

Surgeon: Sanjaya Khanal

Date of Surgery: 07/08/2025 Request Time: 08:00am Duration Time: _____

Admit Type: ☒ Outpatient ☐ Inpatient

Patient Demographics Section

Last Name: Palladino First Name: Alfred

Date of Birth: 06/18/1944 Gender: ☒ Male ☐ Female ☐ Other _____

SSN: _____ Maiden Name (if applicable): _____

Address: 2424 Williams Ct City: Rosamond

State: CA Zip Code: 93560 Phone #: (661) 256-6580

Alternate Phone #: _____ Email: _____

Primary Language: ☒ English ☐ Spanish ☐ Other Interpreter: _____

Allergies: _____ HT _____ WT _____

Parent/Guardian Name (if applicable): _____ DOB: _____

Insurance/Authorization Section

Insurance Name (Primary): Blue Cross HDMG; Aetna HDMG; Medicare

Policy Number: JQS202W19854; Group Number: _____

Insurance Name (Secondary): Blue Cross HDMG; Aetna HDMG; Medicare

Policy Number: JQS202W19854; Group Number: _____

Insurance Type: ☒ HMO ☐ PPO ☐ Medicare ☐ Medi-Cal ☐ Worker's Comp

If HMO, IPA Name: _____ Days Approved: _____

Authorization Number: _____ ☐ N/A Expiration Date: _____

Primary Care Physician: _____ PCP Phone #: _____

Worker's Comp Insurance Name: _____

WC Billing Address: _____ City: _____

State: _____ Zip Code: _____ WC Phone #: _____

Claim #: _____ Date of Injury: _____

Adjuster Name: _____ Phone #: _____

PLEASE ATTACH A COPY OF AUTHORIZATION, IDENTIFICATION CARD, INSURANCE CARD(S) [FRONT & BACK]

Records Reminder List below *(Please check all that apply to this patient/procedure)*

- ☒ SIGNED MD ORDERS *Required*
- ☒ History & Physical *Required*
- ☐ Informed Consent(s) *Required*
- ☐ Medicaid Sterilization Consent *Required* *If Applicable*
- ☐ Clearance Letter
- ☐ Lab
- ☐ EKG Result
- ☐ Chest X-Ray Reports
- ☐ Medication List – *Including medication name(s) and dosage*



Antelope Valley
Medical Center

Procedure/Consent/Equipment Section

SURGERY SCHEDULING FORM

AVMC Scheduling Phone #:

(661) 949-5315

Fax ALL Preadmission Information Paperwork to:

(661) 206-6223

Patient Last Name: Palladino Patient First Name: Alfred

Surgeon: Sanjaya Khanal

Assistant Surgeon: ☐ Yes ☐ No

Contact Person Name: VERONICA Phone #: 661-674-4222 153

Diagnosis: Permanent atrial fibrillation

ICD-10: I48.21

Procedure Type: ☐ Laparoscopic ☐ Laparotomy Anesthesia Type: _____

Procedure Description: TEE (POST WATCHMAN)

CPT Code(s): _____

J Code(s): _____

Area: ☐ Left ☐ Right ☐ Bilateral ☐ N/A Position: ☐ Supine ☐ Prone ☐ Lithotomy ☐ Bilateral

Medicare Inpatient Only Procedure: ☐ Yes ☐ No IP Only CPT Code(s): _____

Special Equipment (Implant/Hardware): ☐ None

Explant: Yes ☐ No ☐ Explant Type: _____ Explant Manufacturer: _____

Implant: Yes ☐ No ☐ Implant Type: _____ Implant Manufacturer: _____

Implant: Yes ☐ No ☐ Implant Type: _____ Implant Manufacturer: _____

☐ C-ARM (Check box if required) How many C-ARM needed: ☐ 1 ☐ 2

Vendor/Company Name: _____ ☐ None

Rep Name: _____ Phone #: _____

Comorbidities: ☐ None ☐ Yes (Check all that apply)

☐ Cardiac ☐ Vascular Disease ☐ Hypertension ☐ Endocrine ☐ Diabetes

☐ Thyroid Disease ☐ Respiratory Disease ☐ Smoker ☐ Sleep Apnea ☐ Kidney Disease

☐ Liver Disease ☐ Neurological Disease ☐ Hematologic ☐ Bleeding Disorders

☐ Other _____

****All of the above fields are mandatory****

AVMC Scheduling Contact Number (661) 949-5315

V.OJEDA@AVCARDIOLOGY.COM

Revised 08/02/2022



AV Cardiology Associates

A M E D I C A L G R O U P

Unless drug ordered is initialed PBO(Prescribed Brand Only) Generic Equivalent will be used

Doctor's Orders

Wt:

Allergies:

Pre-Admission Orders

ADMITTING PHYSICIAN: Sanjaya Khanal

SURGEON: Sanjaya Khanal

DIAGNOSIS: Permanent atrial fibrillation I48.21

SURGERY PROCEDURE: TEE (POST WATCHMAN)

93320,93325,93312

ADMITTING DATE: 07/08/2025 TIME: 06:30 ☒ AM ☐ PM

☐ INPATIENT ☒ OUTPATIENT

DATE OF SURGERY: 07/08/2025 TIME: 08:00 ☒ AM ☐ PM

CBC: ☒ YES ☐ NO LAB TESTS DONE AT: _____

PT, PTT: ☒ YES ☐ NO *Please notify the office if INR is below 1.7 for Cardioversion only

UA: ☐ YES ☒ NO

CHEM. PANEL: ☒ YES ☐ NO

LYTES: ☒ YES ☐ NO

PREGNANCY TEST: ☐ YES ☒ NO

TYPE & SCREEN: ☐ YES ☒ NO NUMBER OF UNITS: _____

OTHER LAB: _____

EKG: ☒ YES ☐ NO EKG DONE AT: _____

CHEST X-RAY: ☐ YES ☒ NO CHEST X-RAY DONE AT: _____

H&P BY: _____

PREP: N/A

ANTIBIOTIC: N/A


THROMBOGARDS: ☐ YES ☒ NO ☐ THIGH HIGH ☐ KNEE HIGH

PRIMARY INSURANCE: _____

AUTHORIZATION REFERENCE #: _____

SECONDARY INSURANCE: _____

AUTHORIZATION REFERENCE #: _____

DATE: 07/02/2025 9:48	TIME:	DOCTOR'S SIGNATURE: 	DATE:	TIME:	NOTED BY:
ANTELOPE VALLEY MEDICAL CENTER 1600 West Avenue J • Lancaster, California 93534 PRE-ADMISSION ORDERS			PATIENT LABEL Palladino, Alfred L. 06/18/1944 2424 Williams Ct Rosamond, CA 93560 (661) 256-6580		