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: 07/17/2025 Request Time: 07:30AM Duration Time: _____
Admit Type: ☐ Outpatient ☑ Inpatient

Patient Demographics Section

Last Name: Simonian First Name: Simon
Date of Birth: 11/03/1946 Gender: ☑ Male ☐ Female ☐ Other _____
SSN: _____ Maiden Name (if applicable): _____
Address: 43745 Byron Dr City: Lancaster
State: CA Zip Code: 93535 Phone #: (818) 621-6676
Alternate Phone #: _____ Email: _____
Primary Language: ☑ English ☐ Spanish ☐ Other Interpreter: _____
Allergies: _____ HT _____ WT _____
Parent/Guardian Name (if applicable): _____ DOB: _____

Insurance/Authorization Section

Insurance Name (Primary): Medicare; LA Care Health Plan; Medicare Secondary
Policy Number: 2P99NR9RG33; Group Number: _____
Insurance Name (Secondary): Medicare; LA Care Health Plan; Medicare Secondary
Policy Number: 2P99NR9RG33; 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*

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Procedure/Consent/Equipment Section

Patient Last Name: Simonian Patient First Name: Simon
Surgeon: Sanjaya Khanal
Assistant Surgeon: ☐ Yes ☐ No _____
Contact Person Name: VERONICA Phone #: 661-674-4222 153
Diagnosis: PAF (paroxysmal atrial fibrillation)
ICD-10: I48.0
Procedure Type: ☐ Laparoscopic ☐ Laparotomy Anesthesia Type: GENERAL

Procedure Description: WATCHMAN
33340 Q0

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: BOSTON ☐ 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 MEDICAL GROUP

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: PAF (paroxysmal atrial fibrillation) I48.0

SURGERY PROCEDURE: WATCHMAN

33340 Q0

ADMITTING DATE: 07/17/2025 TIME: 05:30 ☑ AM ☐ PM

☑ INPATIENT ☐ OUTPATIENT

DATE OF SURGERY: 07/17/2025 TIME: 07:30 ☑ 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 INSURNACE:

AUTHORIZATION REFERENCE #:

SECONDARY INSRURANCE:

AUTHORIZATION REFERENCE #:

DATE:	TIME:	DOCTOR'S SIGNATURE:	DATE:	TIME:	NOTED BY:
06/19/2025	12:16				

ANTELOPE VALLEY MEDICAL CENTER
1600 West Avenue J • Lancaster, California 93534

PRE-ADMISSION ORDERS

PATIENT LABEL

Simonian, Simon 11/03/1946
43745 Byron Dr
Lancaster, CA 93535 (818) 621-6676