SURGERY SCHEDULING FORM

Antelope Valley Medical Center

AVMC Scheduling Phone #:
(661) 949-5315
Fax ALL Preadmission Information Paperwork to:
(661) 206-6223

Surgeon: Pramod Kadambi, MD
Date of Surgery: Fri 07/11/2025 Request Time: 10AM Duration Time: _____
Admit Type: ☑ Outpatient ☐ Inpatient

Patient Demographics Section

Last Name: Pujol First Name: David
Date of Birth: 12/20/1963 Gender: ☑ Male ☐ Female ☐ Other _____
SSN: _____ Maiden Name (if applicable): _____
Address: 44202 Balmuir Ave City: Lancaster
State: CA Zip Code: 93535 Phone #: (661) 941-5643
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 of California;
Policy Number: MBL106M95247 Group Number: _____
Insurance Name (Secondary): _____
Policy Number: _____ Group Number: _____
Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Medi-Cal ☐ Worker's Comp
If HMO, IPA Name: _____ Days Approved: _____
Authorization Number: 266808148 ☐ 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: Pujol Patient First Name: David
Surgeon: Pramod Kadambi, MD
Assistant Surgeon: ☐ Yes ☐ No _____
Contact Person Name: Anita Phone #: 661-674-4222 x150
Diagnosis: Tricuspid insufficiency
ICD-10: I36.1
Procedure Type: ☐ Laparoscopic ☐ Laparotomy Anesthesia Type: General

Procedure Description: TEE

CPT Code(s): 93320; 93312; 93325
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

agutierrez@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: Pramod Kadambi, MD

SURGEON: Pramod Kadambi, MD

DIAGNOSIS: Cirrhosis; Cor pulmonale; (HFpEF) heart failure with preserved ejection

SURGERY PROCEDURE: _____

ADMITTING DATE: Fri 07/11/2025 TIME: 08:00 ☑ AM ☐ PM

☐ INPATIENT ☑ OUTPATIENT

DATE OF SURGERY: Fri 07/11/2025 TIME: 10:00 ☑ 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 INSURNACE: _____

AUTHORIZATION REFERENCE #: _____

SECONDARY INSRURANCE: _____

AUTHORIZATION REFERENCE #: _____

DATE:	TIME:	DOCTOR'S SIGNATURE:
07/08/2025	10:05	

DATE:	TIME:	NOTED BY:

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

PRE-ADMISSION ORDERS

PATIENT LABEL

Pujol, David C. 12/20/1963
44202 Balmuir Ave
Lancaster, CA 93535 (661) 941-5643