



Antelope Valley
Medical Center

SURGERY SCHEDULING FORM

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

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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 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: Pramod Kadambi, MD

SURGEON: Pramod Kadambi, MD

DIAGNOSIS: Tricuspid Insufficiency

SURGERY PROCEDURE: TEE

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 INSURANCE: _____

AUTHORIZATION REFERENCE #: _____

SECONDARY INSURANCE: _____

AUTHORIZATION REFERENCE #: _____

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

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