



**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: 11:00 Duration Time: \_\_\_\_\_

Admit Type: ☒ Outpatient ☐ Inpatient

## Patient Demographics Section

Last Name: Mestaz First Name: Mario

Date of Birth: 06/04/1963 Gender: ☒ Male ☐ Female ☐ Other \_\_\_\_\_

SSN: \_\_\_\_\_ Maiden Name (if applicable): \_\_\_\_\_

Address: 37637 Lilacview Ave City: Palmdale

State: CA Zip Code: 93550 Phone #: (661) 795-7515

Alternate Phone #: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Language: ☒ English ☐ Spanish ☐ Other Interpreter: \_\_\_\_\_

Allergies: \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

Parent/Guardian Name (if applicable): \_\_\_\_\_ DOB: \_\_\_\_\_

## Insurance/Authorization Section

Insurance Name (Primary): Humana HDMG; Molina Healthcare

Policy Number: H75300079; 95118483C Group Number: \_\_\_\_\_

Insurance Name (Secondary): Humana HDMG; Molina Healthcare

Policy Number: H75300079; 95118483C 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

## SURGERY SCHEDULING FORM

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Patient Last Name: Mestaz Patient First Name: Mario

Surgeon: Sanjaya Khanal

Assistant Surgeon: ☐ Yes ☐ No

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

Diagnosis: Paroxysmal atrial fibrillation

ICD-10: I48.0

Procedure Type: ☐ Laparoscopic ☐ Laparotomy Anesthesia Type: \_\_\_\_\_

Procedure Description: TEE ( POST WATCHMAN )

93320, 93312, 93325

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: Paroxysmal atrial fibrillation l48.0

SURGERY PROCEDURE: TEE

93312,93325 ,93312

ADMITTING DATE: 07/08/2025 TIME: 09:30 ☒ AM ☐ PM

☐ INPATIENT ☒ OUTPATIENT

DATE OF SURGERY: 07/08/2025 TIME: 11:00 ☒ 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 INSURNACE: \_\_\_\_\_

AUTHORIZATION REFERENCE #: \_\_\_\_\_

DATE: 07/01/2025 2:35	TIME:	DOCTOR'S SIGNATURE: 	DATE:	TIME:	NOTED BY:
ANTELOPE VALLEY MEDICAL CENTER 1600 West Avenue J • Lancaster, California 93534  <b>PRE-ADMISSION ORDERS</b>			PATIENT LABEL Mestaz, Mario L. 06/04/1963 37637 Lilacview Ave Palmdale, CA 93550 (661) 795-7515		