



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: 09:00AM Duration Time: _____

Admit Type: ☒ Outpatient ☐ Inpatient

Patient Demographics Section

Last Name: Beauchamp N First Name: Michele

Date of Birth: 08/21/1949 Gender: ☐ Male ☒ Female ☐ Other _____

SSN: _____ Maiden Name (if applicable): _____

Address: 2726 Brentwood Dr City: Lancaster

State: CA Zip Code: 93536 Phone #: (661) 948-2668

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; Blue Shield Federal; Blue Cross of California

Policy Number: 3GQ1PN9ED03; Group Number: _____

Insurance Name (Secondary): Medicare; Blue Shield Federal; Blue Cross of California

Policy Number: 3GQ1PN9ED03; 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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Medical Center

Procedure/Consent/Equipment Section

SURGERY SCHEDULING FORM

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(661) 949-5315

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(661) 206-6223

Patient Last Name: Beauchamp N Patient First Name: Michele

Surgeon: Sanjaya Khanal

Assistant Surgeon: ☐ Yes ☐ No

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

Diagnosis: Atrial fibrillation, transient

ICD-10: I48.91

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: Atrial fibrillation, transient I48.91

SURGERY PROCEDURE: TEE

93320,93312,93325

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

☐ INPATIENT ☒ OUTPATIENT

DATE OF SURGERY: 07/08/2025 TIME: 09:00 ☒ 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: 07/01/2025 12:55	TIME: 12:55	DOCTOR'S SIGNATURE: 	DATE: 08/21/1949	TIME: 08/21/1949	NOTED BY: (661) 948-2668
ANTELOPE VALLEY MEDICAL CENTER 1600 West Avenue J • Lancaster, California 93534 PRE-ADMISSION ORDERS			PATIENT LABEL Beauchamp N, Michele 2726 Brentwood Dr Lancaster, CA 93536		