CALIFORNIA DIABETES AND PREGNANCY PROGRAM DATA FORM

Leave Blank

1. Affiliate Initials (Person Completing Form) USE CAPS **2. County** **3. Region** **4. Affiliate** **5. Satellite**

*DEMOGRAPHICS

6. Race/Ethnicity (May choose up to 3)
- ☐ Black/African American
- ☐ Hispanic/Latina
- ☐ Hawaiian Native/Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Asian (Chinese, Japanese, etc)
- ☐ Southeast Asian (Vietnamese, etc)
- ☐ Asian Indian/Indian Sub-Continent
- ☐ White/Caucasian
- ☐ Unknown
- ☐ Other If race is other: USE CAPS

7. Preferred Reading Language
- ☐ English
- ☐ Spanish
- ☐ Unknown
- ☐ Other

If language is other: USE CAPS

8. Payment Method (may choose up to 3)
- ☐ Private Ins. ☐ HMO ☐ PPO
- ☐ Medi-Cal ☐ Self Pay ☐ Unknown
- ☐ None ☐ Other

If payment is other: USE CAPS

9. Mat. Age **10. Grav** **11. Para**

9, 10, 11 complete **after this delivery**

12. Education Level
- ☐ No Schooling
- ☐ K – 3rd Grade
- ☐ 4 – 8th Grade
- ☐ Any High School/HS Grad/GED
- ☐ Any College/College Grad/Post Grad
- ☐ Unknown

*PRECONCEPTION

13. Pre-preg Wt (lbs) **14. Meas. Ht. (")** **15. Preconception care** ☐ Yes ☐ No ☐ UNK ☐ NA **16. Preconception A1c** **17. Date of preconception A1c**

*PRENATAL/PREGNANCY

18. EDD (most accurate date- AFP) **19. Date GDM/IGT Dx by Lab** **20. Earliest prenatal A1c** **21. Date of prenatal A1c**

FIRST Prenatal Sweet Success Visit **22. Date of Visit** **23. Weight in pounds** **24. DM Dx/Tx (use codes on back)**

*Check:
Glyb ___ Met___ Acar___ Oth_____
Insulin pump___

LAST Prenatal Sweet Success Visit **25. Date of Visit** **26. Weight in pounds** **27. DM Dx/Tx (use codes on back)**

*Check:
Glyb ___ Met___ Acar___ Oth_____
Insulin pump___

*DELIVERY/POSTPARTUM

28. Pregnancy outcome ☐ Live Birth ☐ Fetal Death ☐ Spontaneous Abortion ☐ Other ☐ Unknown

29. Multiple Birth ☐ No ☐ Yes, Specify number: ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

30. This form filled out for baby ☐ Single birth or 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more ☐ Unknown

31. Date of Delivery **32. Birth weight in grams** **33. Baby's Gender** ☐ Male ☐ Female ☐ Unknown

34. Method of delivery ☐ Vaginal ☐ VBAC ☐ C/S*, Primary ☐ C/S*, Rep ☐ Unknown
*Specify why on back of form

35. Baby discharged w/mother? ☐ Yes ☐ No* # newborn days in hosp: ☐ Unknown
*Specify why on back of form

36. Congenital anomalies ☐ No ☐ Yes* * Specify type on back of form ☐ Unknown

37. Feeding at discharge ☐ Breast milk only ☐ Formula only ☐ Breast milk & Formula ☐ Unknown

38. DM Dx/Tx Postpartum (Use codes on back)

*Check:
Glyb ___ Met___ Acar___
Other_____
Insulin pump___

39. Postpartum DM Dx by ☐ FBS ☐ Other ☐ NA ☐ 2º OGTT ☐ UNK

40. Date Postpartum visit

a) Face-to-Face b) Phone c) FAX, Email Total

41. SS Visits + + = ☐ Unknown

CONVERSION OF POUNDS AND OUNCES TO GRAMS

Pounds	Ounces 0	1	2	3		4	5	6	7		8	9	10	11		12	13	14	15
0		28	57	85		113	142	170	198		227	255	283	312		340	369	397	425
1	454	482	510	539		567	595	624	652		680	709	737	765		794	822	850	879
2	907	936	964	992		1021	1049	1077	1106		1134	1162	1191	1219		1247	1276	1304	1332
3	1361	1389	1417	1446		1474	1503	1531	1559		1588	1616	1644	1673		1701	1729	1758	1786
4	1814	1843	1871	1899		1928	1956	1984	2013		2041	2070	2098	2126		2155	2183	2211	2240
5	2268	2296	2325	2353		2381	2410	2438	2466		2495	2523	2551	2580		2608	2637	2665	2693
6	2722	2750	2778	2807		2835	2863	2892	2920		2948	2977	3005	3033		3062	3090	3118	3147
7	3175	3203	3232	3260		3289	3317	3345	3374		3402	3430	3459	3487		3515	3544	3572	3600
8	3629	3657	3685	3714		3742	3770	3799	3827		3856	3884	3912	3941		3969	3997	4026	4054
9	4082	4111	4139	4167		4196	4224	4252	4281		4309	4337	4366	4394		4423	4451	4479	4508
10	4536	4564	4593	4621		4649	4678	4706	4734		4763	4791	4819	4848		4876	4904	4933	4961
11	4990	5018	5046	5075		5103	5131	5160	5188		5216	5245	5273	5301		5330	5358	5386	5415
12	5443	5471	5500	5528		5557	5585	5613	5642		5670	5698	5727	5755		5783	5812	5840	5868
13	5897	5925	5953	5982		6010	6038	6067	6095		6123	6152	6180	6209		6237	6265	6294	6322
14	6350	6379	6407	6435		6464	6492	6520	6549		6557	6605	6634	6662		6690	6719	6747	6776
15	6804	6832	6860	6889		6917	6945	6973	7002		7030	7059	7087	7115		7144	7172	7201	7229
16	7257	7286	7313	7342		7371	7399	7427	7456		7484	7512	7541	7569		7597	7626	7654	7682
17	7711	7739	7768	7796		7824	7853	7881	7909		7938	7966	7994	8023		8051	8079	8108	8136
18	8165	8192	8221	8249		8278	8306	8335	8363		8391	8420	8448	8476		8504	8533	8561	8590
19	8618	8646	8675	8703		8731	8760	8788	8816		8845	8873	8902	8930		8958	8987	9015	9043
20	9072	9100	9128	9157		9185	9213	9242	9270		9298	9327	9355	9383		9412	9440	9469	9497
21	9525	9554	9582	9610		9639	9667	9695	9724		9752	9780	9809	9837		9865	9894	9922	9950
22	9979	10007	10036	10064		10092	10120	10149	10177		10206	10234	10262	10291		10319	10347	10376	10404

CODES FOR 24, 27, 38

Code	SS Dx	SS Tx
00	None	NA
01	GDM	Diet only
02	GDM	Oral Meds*
03	GDM	Insulin*
10	GDM	Oral Meds & Insulin*
04	Type 1	Insulin*
05	Type 2	Diet only
06	Type 2	Oral Meds*
07	Type 2	Insulin*
12	Type 2	Oral Meds & Insulin*
08	IGT	Diet only
20	History of GDM only	Diet only
88	Not tested	NA
99	UNK	NA

CALIFORNIA COUNTY CODES

County Code	County	County Code	County	County Code	County
01	Alameda	21	Marin	41	San Mateo
02	Alpine	22	Mariposa	42	Santa Barbara
03	Amador	23	Mendocino	43	Santa Clara
04	Butte	24	Merced	44	Santa Cruz
05	Calaveras	25	Modoc	45	Shasta
06	Colusa	26	Mono	46	Sierra
07	Contra Costa	27	Monterey	47	Siskiyou
08	Del Norte	28	Napa	48	Solano
09	El Dorado	29	Nevada	49	Sonoma
10	Fresno	30	Orange	50	Stanislaus
11	Glenn	31	Placer	51	Sutter
12	Humboldt	32	Plumas	52	Tehama
13	Imperial	33	Riverside	53	Trinity
14	Inyo	34	Sacramento	54	Tulare
15	Kern	35	San Benito	55	Tuolumne
16	Kings	36	San Bernardino	56	Ventura
17	Lake	37	San Diego	57	Yolo
18	Lassen	38	San Francisco	58	Yuba
19	Los Angeles	39	San Joaquin		
20	Madera	40	San Luis Obispo		

34) Reason for Cesarean Section	OTHER COMMENTS:
35) Reason for Infant Admission	
36) Specific Congenital Anomalies	

- Please fill in the Data Form clearly. Use **PEN** only. Follow the *Data Collection Manual* coding instructions.
- Never use "99" as an unknown code (except for #24, 27, 38). Always fill in "?" in the first box.
- Complete CDAPP Data Forms at postpartum visit or within 6-8 weeks postpartum.
- Send your original completed CDAPP Data Forms to your Regional Coordinator by the deadlines.
- Call either your Regional Coordinator or the Data Coordinator (562-945-6484) with questions.