

**CALIFORNIA DIABETES & PREGNANCY PROGRAM – SWEET SUCCESS 2008 DATA FORM**

<b>1. Region</b>		<b>2. Affiliate</b>		<b>3. Satellite</b>		<b>4. Collector's Initials</b>		<b>5. Maternal Age</b> (after pregnancy)			
<b>6. Hispanic Origin</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>7. Race/Ethnicity</b> <input type="checkbox"/> White / Caucasian <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Native American / Alaska Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Far East Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Black/African American <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hawaiian Native / Pacific Islander						<b>8. Education Level</b> <input type="checkbox"/> No schooling <input type="checkbox"/> Kindergarten to 6 <sup>th</sup> Grade <input type="checkbox"/> 7 <sup>th</sup> to Any High School <input type="checkbox"/> High School Graduate / GED <input type="checkbox"/> Any Tech School or College/Grad /Post Graduate <input type="checkbox"/> Unknown			<b>9. Payment Method</b> (select up to 2) <input type="checkbox"/> Private Insurance – PPO/Indemnity <input type="checkbox"/> Private Insurance – HMO <input type="checkbox"/> MediCal – Fee for Service <input type="checkbox"/> MediCal - HMO <input type="checkbox"/> Self-pay <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Other		
<b>10. Pre-pregnancy Wt</b> lbs.		<b>11. Measured Ht</b> ins.		<b>12. Gravida</b>		<b>13. Para</b> (after current pregnancy)					
<b>14A. Preconception Care</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk/NA				<b>14B. Most recent preconception A1c</b> Date			<b>14C. Results</b> (value)				
<b>15. Estimated Date of Delivery</b>				<b>16. Date of first prenatal A1c</b>			<b>17. Results</b> (value)				
<b>18. Edinburgh Score: Third Trimester</b>			<b>Post Partum</b>			<b>19A. Date of GDM diagnosis by lab</b>					
<b>19B. GDM Screening:</b> <input type="checkbox"/> 50 gm <input type="checkbox"/> 75 gm <input type="checkbox"/> 100 gm <input type="checkbox"/> Other <input type="checkbox"/> Unk						<b>19C. Glucose Test Results: Fasting</b> 1° 2° 3°					
<b>First Sweet Success Visit</b>			<b>Last Sweet Success Visit</b>			<b>Post Partum Sweet Success</b>					
<b>20. Date</b>		<b>21. Weight (lbs)</b>		<b>24. Date</b>		<b>25. Weight (lbs)</b>		<b>27. Date</b>		<b>28. Weight (lbs)</b>	
<b>22. Diabetes Diagnosis/Reason for Referral</b> <input type="checkbox"/> None <input type="checkbox"/> GDM <input type="checkbox"/> Type 1 (DM1) <input type="checkbox"/> Type 2 (DM2) <input type="checkbox"/> PreDiabetes/IGT/IFG <input type="checkbox"/> History of GDM (no test) <input type="checkbox"/> 1 abnormal value only <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____							<b>29. Type of Post Partum Contact</b> (check all that apply) <input type="checkbox"/> Office Visit <input type="checkbox"/> Blood glucose testing / laboratory <input type="checkbox"/> Follow-up telephone call <input type="checkbox"/> Patient decline to participate <input type="checkbox"/> None <input type="checkbox"/> Unknown <b>30. Post partum diabetes diagnosis based on</b> <input type="checkbox"/> Fasting <input type="checkbox"/> 2°OGTT <input type="checkbox"/> Unk <input type="checkbox"/> Not Done <input type="checkbox"/> Other				
<b>23A. Treatment</b> <input type="checkbox"/> Diet and Exercise Only <input type="checkbox"/> Oral Medications <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Meds and Insulin <input type="checkbox"/> Unknown				<b>26A. Treatment</b> <input type="checkbox"/> Diet and Exercise Only <input type="checkbox"/> Oral Medications <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Meds and Insulin <input type="checkbox"/> Unknown			<b>31. Post Partum Diabetes Diagnosis</b> <input type="checkbox"/> None <input type="checkbox"/> Type 1 (DM1) <input type="checkbox"/> Type 2 (DM2) <input type="checkbox"/> Impaired Glucose Tolerance (IGT) <input type="checkbox"/> Impaired Fasting Glucose (IFG) <input type="checkbox"/> Both IGT/IFG <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown				
<b>23B. Treatment Details</b> (check all that apply) <input type="checkbox"/> Glyburide <input type="checkbox"/> Metformin <input type="checkbox"/> Insulin (Rapid: Aspart, Lispro, Apidra) <input type="checkbox"/> Insulin (Short: Regular) <input type="checkbox"/> Insulin (Intermediate: Humulin N, Novolin N) <input type="checkbox"/> Insulin (Long: Detemir, Glargine) <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)				<b>26B. Treatment Details</b> (check all that apply) <input type="checkbox"/> Glyburide <input type="checkbox"/> Metformin <input type="checkbox"/> Insulin (Rapid: Aspart, Lispro, Apidra) <input type="checkbox"/> Insulin (Short: Regular) <input type="checkbox"/> Insulin (Intermediate: Humulin N, Novolin N) <input type="checkbox"/> Insulin (Long: Detemir, Glargine) <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)			<b>32A. Post Partum Treatment</b> <input type="checkbox"/> Diet and Exercise <input type="checkbox"/> Oral Medications <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Meds & Insulin <input type="checkbox"/> Unknown <input type="checkbox"/> None <b>32B. Treatment Details</b> (check all that apply) <input type="checkbox"/> Glyburide <input type="checkbox"/> Metformin <input type="checkbox"/> Insulin (Rapid: Aspart, Lispro, Apidra) <input type="checkbox"/> Insulin (Short Acting: Regular) <input type="checkbox"/> Insulin (Intermediate: Humulin N, Novolin N) <input type="checkbox"/> Insulin (Long: Detemir, Glargine) <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> Other				
<b>33. Total Sweet Success Visits:</b>			<b>Face to face</b>		<b>Phone</b>		<b>Fax-E-mail</b>		<b>34. Unknown</b>		
<b>35. Seen by which professionals in SS during this pregnancy?</b> <input type="checkbox"/> Behavioral Medicine <input type="checkbox"/> Perinatologist (MFM) <input type="checkbox"/> CPHW/MA <input type="checkbox"/> Physicians Assistant <input type="checkbox"/> Exercise Physiologist <input type="checkbox"/> Reg. Dietitian <input type="checkbox"/> Health Educator <input type="checkbox"/> RN/Advanced Practice Nurse <input type="checkbox"/> Obstetrician <input type="checkbox"/> Unk <b>Are any CDE? Yes/No</b>						<b>36. Which maternal/fetal screenings were completed during this pregnancy?</b> <input type="checkbox"/> Retinal Examination <input type="checkbox"/> Non-stress/amniotic fluid index <input type="checkbox"/> 24° Urine for Protein <input type="checkbox"/> Other <input type="checkbox"/> Fetal echocardiogram <input type="checkbox"/> Unknown <input type="checkbox"/> Advanced ultrasound <input type="checkbox"/> Non-stress test					

**37. Adherence to Sweet Success Interventions** (as of last antepartum visit)

	Yes ( $\geq$ 80% adherence)	No (< 80% adherence)	Not Assessed
Keeps scheduled appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-monitors and records blood glucose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documents food intake as requested	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Demonstrates evidence of exercise adherence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintains blood glucose within rec. parameters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Takes medications as directed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

**38. Date of Delivery** (MM/DD/YYYY)

**39A. Maternal Issues/Outcomes** (select all that apply)

- Term delivery without complications
- Antepartum hospitalization
- Prolonged post-partum hospitalization
- Maternal readmission within 28 days of delivery
- Maternal death  
cause: \_\_\_\_\_
- Unknown

**39B. Reason for (Re) Admission / Prolonged Stay**

- Preterm Labor or PROM
  - Hemorrhage
  - Infection (sepsis)
  - Thrombosis/Embolism (clots)
  - Glycemia control (bld. glucose)
  - Management of blood pressure
  - Neurological complications
  - ICU Care
  - Other
  - Unknown
- Complications due to diabetes?**  
Yes No Unknown

**Neonatal Outcome**

**40. Pregnancy Outcome**  Live Birth  Elective Termination  Spontaneous Abortion  Fetal Death  Unknown  Other

**41A. Multiple Birth**  Yes  No  Unk     **41B. Number of Infants** \_\_\_\_\_     **42. Baby's gender**  Male  Female  Ambiguous genitalia  Unk

**43. Birthweight (in gms)** \_\_\_\_\_     **44. Feeding at discharge**  Breast milk  Formula  Breast & formula  Unknown

**45. Type of Labor**  Spontaneous  Induced  None  Unk     **46A. Method of delivery**  Vaginal  VBAC  Cesarean  Unknown  Other

**46B. Reason for Cesarean**

- Repeat
- Elective
- Multifetal pregnancy
- Placenta previa
- Malpresentation
- Cephalopelvic disproportion
- Non-reassuring fetal HR
- Failure to progress
- Preterm delivery
- Estimated macrosomia
- Other \_\_\_\_\_
- Unknown

**47A. Baby's Outcome**

- Discharged home with mother
- Delayed discharge from Mother/Baby Unit or Normal Nursery
- Admitted to NICU (beyond transitional stage)
- Readmitted to hospital at less than 28 days of life
- Died within first 28 days of life  
cause: \_\_\_\_\_
- Unknown

**47B. Reason for delayed discharge/readmit/death**

- Complications of prematurity
- Birth defects, chromosomal/congenital anomalies
- Respiratory problems
- Infection/suspected infection
- Hypoglycemia
- Hyperbilirubinemia/Jaundice
- Apnea or bradycardia
- Feeding difficulties
- Shoulder dystocia
- Brachial Plexus palsy
- Unknown  Other

**47C. Number of days in hospital** \_\_\_\_\_

**47D. Chromosomal or congenital anomalies**  No  Yes

- Any chromosomal anomaly
  - Central nervous system
  - Cardiac or vascular
  - Skeletal
  - Pulmonary
  - Gastrointestinal
  - Genitourinary
  - Skin and soft tissue (clefts)
  - Other
- Describe: \_\_\_\_\_
- Unknown

**48. Other comments**

**49. Source of Data Reported**

- Chart
- Patient recall
- Telephone interview
- Follow-up survey
- Combination of above
- Unknown
- Other

For clients delivering twins, triplets or higher order multiples please attach additional pages with questions 40 to 47D completed for each infant.

For Data Center Use Only  
Data form number \_\_\_\_\_