

NorDIP data collection form

Section 1: Demographic information

Box for woman's details (attach label if possible)
(If no consent give NHS no. and hospital no. only)

Surname _____

Forename _____

Date of birth _____

Hospital number _____

NHS number _____

Address at delivery _____

Booking Hospital _____

Delivery Hospital _____

1. Ethnic group

White: British Irish Any other white background, please specify _____

Mixed: White and Black Caribbean White and Black African White and Asian Any other mixed

Asian or Asian British: Indian Pakistani Bangladeshi Any other Asian background

Black or Black British: Caribbean African Any other black background

Other ethnic group: Chinese Any other, please specify _____

Not stated

Section 2: Obstetric history

2. Parity

Number of completed pregnancies \geq 24 weeks (all live and stillbirths) _____

Number of pregnancies $<$ 24 weeks _____

(Note multiples count as one pregnancy)

3. Were there any previous pregnancy problems? *If yes tick all that apply below:* Yes No

Pre-eclampsia (hypertension and proteinuria)	<input type="checkbox"/>	Stillbirth	<input type="checkbox"/>
Previous gestational diabetes	<input type="checkbox"/>	Neonatal death	<input type="checkbox"/>
Previous caesarean section	<input type="checkbox"/>	Baby with congenital anomaly	<input type="checkbox"/>
Pre-term birth ($<$ 37weeks) or mid trimester loss	<input type="checkbox"/>	Previous baby $>$ 4500g	<input type="checkbox"/>
Three or more miscarriages	<input type="checkbox"/>	Post partum haemorrhage requiring transfusion	<input type="checkbox"/>

Section 3: Medical history

4. Type of diabetes

Type 1

Type 2

Any other type of diabetes, please specify _____

Unknown

Age when diabetes diagnosed _____

5. Family history of diabetes

Type 1 or Type 2 diabetes in first degree relative (parent, sibling, child) Yes No

Section 4: Preconception measures

6. Date of LMP _____ *Note: refers to measures before this date.*

7. Is there documented evidence that the woman received preconception information and advice before discontinuing contraception?

Yes

No

8. Diabetes treatment regime prior to LMP

Metformin	<input type="checkbox"/>	Sulphonylurea or glitinide	<input type="checkbox"/>
Insulin Pump Therapy	<input type="checkbox"/>	Gliptin	<input type="checkbox"/>
Glargine	<input type="checkbox"/>	GLP-1 analogue	<input type="checkbox"/>
Detemir	<input type="checkbox"/>	Glitazone	<input type="checkbox"/>
Any other insulin	<input type="checkbox"/>	None of the above	<input type="checkbox"/>

9. Was HbA1c recorded within 3 months of LMP? *If yes, give value and date of most recent value before LMP*

Date _____ mmol/mol _____

10. Retinopathy status prior to LMP

Not available	<input type="checkbox"/>
R0 - No retinopathy	<input type="checkbox"/>
R1 - Background retinopathy	<input type="checkbox"/>
R2 - Proliferative retinopathy	<input type="checkbox"/>
R3 - Proliferative retinopathy	<input type="checkbox"/>
Retinopathy/grade unknown	<input type="checkbox"/>

11. Maculopathy status prior to LMP

Not available/not known	<input type="checkbox"/>
M0 - No maculopathy	<input type="checkbox"/>
M1 – Maculopathy	<input type="checkbox"/>

12. Last microalbuminuria measured within 12 months of LMP? Date of measurement _____

Microalbuminuria <input type="checkbox"/>	Proteinuria <input type="checkbox"/>	None <input type="checkbox"/>	Not available <input type="checkbox"/>
(ACR>3.5 mg/mmol)	(>300mg/L)		

13. Plasma creatinine level prior to 1st day of LMP Micromols/l _____ Date _____ Not available

14. Angina or MI diagnosed prior to last LMP? Yes No Not known

15. Treated for hypertension Yes No Not known

Section 5: Booking measures

16. Expected date of delivery (by scan) _____
17. Height at booking _____ (cms)
18. Weight at booking _____ (kg)
19. Date of booking appointment (community or hospital) _____
20. Date of first contact with specialist diabetes antenatal team if different _____

Section 6: Periconception exposures

21. Folic acid taken at date of LMP? 5mg 400mcg None Not known
22. On aspirin during first trimester? Yes No Not known
23. Smoking at LMP Current Ex-smoker Never smoked Non-smoker, history unknown
24. On statins prior to LMP? Yes No Not known Date stopped _____
25. On ACE inhibitors prior to LMP? Yes No Not known Date stopped _____
26. List medications taken between LMP and 13 weeks (not including hypoglycaemic therapy)

Name	Date Started	Date Stopped

Section 7: Pregnancy measures

27. Retinopathy status before 16 weeks

Retinopathy (any grade) Yes No Not available

28. Retinopathy status at or around 28 weeks

Retinopathy (any grade) Yes No Not available

29. Was a four chamber cardiac anomaly scan with outflow tract visualisation carried out?

Yes No Not known

30. Was ultrasound assessment of fetal growth and amniotic fluid volume performed?

Yes No Not known Date of first growth assessment _____

31. Number of growth scans _____

Pregnancy complications

32. Was the woman admitted to hospital for hypoglycaemia?

Yes No Not known

33. Was the woman admitted to HDU or ICU during pregnancy?

Yes No Not known

34. Did any of these complications occur during pregnancy?

Diabetic ketoacidosis requiring admission	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Severe hypoglycaemia requiring help from another person	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Pre-eclampsia (hypertension 140/90 and proteinuria)	Yes <input type="checkbox"/>	No <input type="checkbox"/>

35. HbA1c measurements during pregnancy

First measurement after LMP (mmol/l) _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

Measurement _____ Date _____

36. Treatment regime immediately before delivery

Metformin	<input type="checkbox"/>	Sulphonylurea or glitinide	<input type="checkbox"/>
Insulin Pump Therapy	<input type="checkbox"/>	Gliptin	<input type="checkbox"/>
Glargine	<input type="checkbox"/>	GLP-1 analogue	<input type="checkbox"/>
Detemir	<input type="checkbox"/>	Glitazone	<input type="checkbox"/>
Any other insulin	<input type="checkbox"/>	None of the above	<input type="checkbox"/>

Section 8: Delivery

Date of delivery _____ Time of delivery _____

Number of fetuses _____ *Please complete additional form (delivery section only) for each baby*

37. Labour:

Spontaneous	<input type="checkbox"/>	Induced	<input type="checkbox"/>
Never in labour	<input type="checkbox"/>		

38. Management of blood glucose in labour:

None	<input type="checkbox"/>	Monitoring only	<input type="checkbox"/>
IV dextrose and insulin infusion	<input type="checkbox"/>	Other	<input type="checkbox"/>
Not known	<input type="checkbox"/>		

39. Delivery:

Spontaneous vertex	<input type="checkbox"/>	Spontaneous other cephalic	<input type="checkbox"/>
Low forceps not breech	<input type="checkbox"/>	Other forceps, not breech	<input type="checkbox"/>
Ventouse, vacuum extraction	<input type="checkbox"/>	Breech including partial breech extraction	<input type="checkbox"/>
Breech extraction NOS	<input type="checkbox"/>	Elective caesarean	<input type="checkbox"/>
Emergency caesarean	<input type="checkbox"/>	Other	<input type="checkbox"/>

40. Was there documented shoulder dystocia?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
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41. Was the woman admitted to HDU or ICU after delivery? (but before discharge from hospital – i.e. do not include readmissions)

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Not known	<input type="checkbox"/>
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Section 9: Baby

Baby's name _____

Baby's NHS number _____

Baby's hospital number _____

Hospital transferred to _____

42. Sex Male Female Uncertain Unknown

43. Birth weight _____ gms

44. Outcome: Liveborn AP stillbirth
IP stillbirth Fetal loss <24 weeks
TOP Date of death _____

45. Congenital abnormality? Yes No

If yes, please describe _____

46. Highest level of care received by baby: Normal care Level 3 special care
Level 2 intensive care Level 1 intensive care
Not known

47. Reason for this level of care (tick all that apply):

Management of hypoglycaemia Yes No
Weight and/or gestation criteria Yes No
Tube feeding Yes No
Respiratory symptoms Yes No
Maternal diabetes without any of the above Yes No
Other (free text) _____

48. Apgar score at 5 mins _____

49. Neonatal glucose measurement lowest value recorded _____ Date _____ Time _____

50. If the baby was hypoglycaemic, was there either:

Decreased level of consciousness Yes No
Seizures Yes No

51. What was the first feed given to the baby? Breast milk Formula Other

52. Feeding at discharge: Exclusive breast Mixed Exclusive formula

53. Date of baby's discharge _____

Section 10: Postnatal information

54. Was contraceptive advice given prior to discharge? Yes No

55. Was a follow up appointment for diabetic management arranged prior to discharge from hospital? Yes No

56. Date of woman's discharge _____