National ART Surveillance System (NASS)

Welcome

The National ART Surveillance System (NASS) is a Web-based ART data reporting system supported by CDC under a contract with Westat -- Contract No. 200-2004-06702, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. NASS is the only CDC-approved data reporting system for ART procedures initiated in 2004, 2005, 2006, 2007, and 2008. ART clinics that are participating in the NASS reporting system will be considered to be in compliance with federal reporting requirements of the Fertility Clinic Success Rate and Certification Act of 1992 [FCSRCA], Section 2(a) of P.L. 102-493 (42 U.S.C. 263a-1(a)).

If you would like more information on how to report your data please call the NASS Help Desk line at 1-888-650-0822.

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Form Approved

OMB Control Number: 0920-0556

Expiration Date: 09/30/2009

Public reporting burden of this collection of information is estimated to average 37 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0556)

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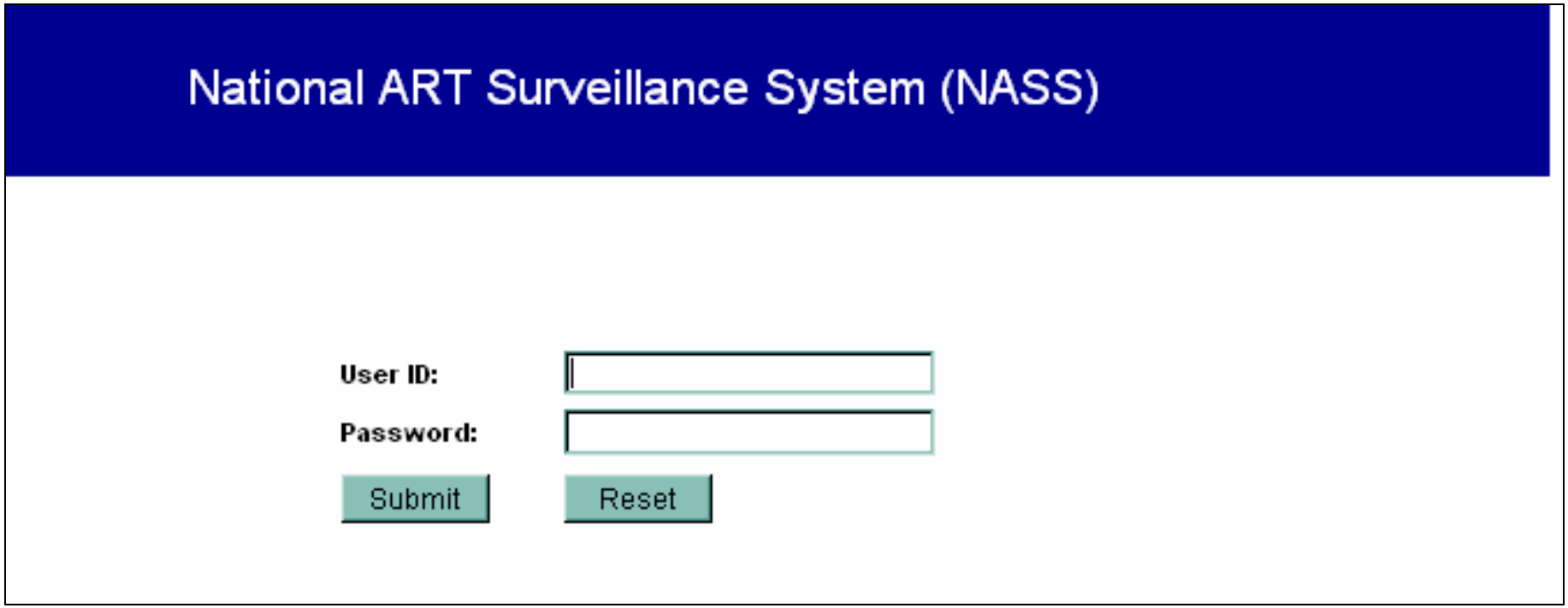
National ART Surveillance System (NASS)
User ID:
Password:
Submit
Reset

National ART Surveillance System (NASS)

User: Dannie Ameti (ameti_d)

Select Reporting Year

Select Reporting Year: ---Select--- Go

Confidentiality Information: Safeguards for Individuals and Establishments Against Invasions of Privacy

Information contained in this data collection system, which would permit identification of any individual or establishment, has been collected with a guarantee that it will be held in strict confidence by the contractor and CDC, will be used only for purposes stated in this surveillance activity, and will not be disclosed or released to anyone other than authorized staff of CDC without the consent of the individual or establishment in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

The collection of these data by CDC and its contractor is authorized by Section 306 of the Public Health Service Act (42 USC 242k). The purpose of this data collection effort is for assisted reproductive technology (ART) programs to fulfill annual reporting year requirements required by the Fertility Clinic Success Rate and Certification Act (FCSRCA), Section 2 [a] of P.L.102-493 [42 USC 263 (a)-1]. Information collected under the authority of Section 306 of the Public Health Service Act (42 USC 242k) will be used by CDC to publish an annual Assisted Reproductive Technology Success Rates Report as mandated by law as well as for publication of other statistical and analytic summaries and epidemiologic studies. ART programs will be identified only in the tables routinely published in the annual ART Success Rates Report, but not in any other statistics produced by the CDC or by organizations that may receive authorization to use CDC data. The identity of, or information about individual patients will not be disclosed in any reports or statistical research.

Known clinics and practitioners providing ART services in a given reporting year are required to submit and verify their ART cycle data under FCSRCA provisions. Those that do not report their data or do not provide verification that tabulated success rates are correct, are listed in the annual Success Rates Report as non-reporters as required for publication by the FCSRCA.

No information collected under the authority of Section 306 of the Public Health Service Act (42 USC 242k) will be used by CDC for any purpose other than the purpose for which it was supplied, and such information may not be published or released in any other form that would identify a particular individual or ART program to anyone other than authorized CDC staff, unless the individual or ART program consents to its release.

Reporting Year: 2009

Clinic Profile & Data >> Enter Clinic Profile >> Name&Address

Name&Address	Key Staff	Service&Profile	Lab&Certification

Reporting Year Clinic Name:

This is the name as it is going to appear at the top of the CDC clinic report:

Name 1:

Name 2:

City: State: ---Select---

Current Clinic Information:

Status: ---Select---

NOTE: Reorganization is a change in two of three key staff - the Practice, Medical, or Lab Director - or a change in clinic ownership or affiliation.

Name at time of data submission will reflect changes that occurred since the reporting year:

Name 1:

Name 2:

Address 1:

Address 2:

City: State: ---Select--- Zip code (99999-9999):

Phone (999) 999-9999: Fax (999) 999-9999:

E-mail: SART ID: 1188

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Clinic Profile & Data >> Enter Clinic Profile >> Key Staff

Name&Address	Key Staff	Service&Profile	Lab&Certification

Choose the key staff role to update by clicking on the associated key staff title underlined in the first column of boxes.

Key Staff	Staff Name	Degree	Phone	Fax	E-mail
Practice Director					
Medical Director					
Lab Director					
Data Manager					

Clinic Profile & Data >> Enter Clinic Profile >> Service&Profile

Name&Address	Key Staff	Service&Profile	Lab&Certification

Services and Profile:

SART member: ◯ Yes ◯ No

Do ART services include gestational carriers? ◯ Yes ◯ No

Are ART services available for single women? ◯ Yes ◯ No

Does clinic have a donor egg program? ---Select---

Does clinic have a donor embryo program? ◯ Yes ◯ No

Does clinic offer freezing extra embryos? ◯ Yes ◯ No

Embryo Lab Information:

Total number of embryo labs: [ ] NOTE: Enter the total number of embryo labs currently used by your ART program.

Add New Lab

Lab Summary:

No labs have been added for this reporting year.

New Lab

Current Embryo Lab Information:

Name 1: [ ]

Name 2: [ ]

Address 1: [ ]

Address 2: [ ]

City: [ ] State: ---Select--- Zip Code (99999-9999): [ ]

Phone (999) 999-9999: [ ] Fax (999) 999-9999: [ ]

E-mail: [ ]

Current Embryo Lab Certification Status (Select a status for each accrediting body below):

College of American Pathologists Reproductive Laboratory Accreditation Program (CAP): ---Select---

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): ---Select---

New York Tissue Bank Program (NYSTB): ---Select---

National ART Surveillance System (NASS)

User: Karen Hamre (Hamre_K)
Reporting Year: 2007

Select/Add Patient

Find Existing Patient

To find an existing patient, search by entering any combination of Date of Birth, Optional ID 1 or Optional ID 2. For a list of ALL patients, leave search fields blank and click Find button.

Date of Birth: mm / dd / yyyy

Optional Identifier 1:

Optional Identifier 2:

NASS Patient ID:

Find | Clear Fields

Add New Patient

To begin the process of adding a patient, enter the patient's date of birth.

Date of Birth (mm/dd/yyyy):

Add | Clear Field

Select/Add Patient >> Update Patient Profile

Patient:

NASS Patient ID: 1023-10000-1 Date of Birth: 01/01/1980 Optional ID 1: abc Optional ID 2:

Patient Optional Identifiers:

Optional Identifier 1: (max. 3 digits or characters) abc

Optional Identifier 2: (max. 4 digits or characters)

Patient Profile:

Date of Birth (mm/dd/yyyy): 01/01/1980

Ethnicity: Not ascertained by clinic

Race (based on patient self report):

Select all that apply:

- [x] White
- [ ] Black or African American
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] American Indian or Alaska Native

Select reason race not reported:

- [ ] Refused
- [ ] Patient doesn't know
- [ ] Not ascertained by clinic

Height: Report height in units as recorded in medical chart. Do not convert measurements.

5 Feet **and/or** 6 Inches

or

Centimeters

or

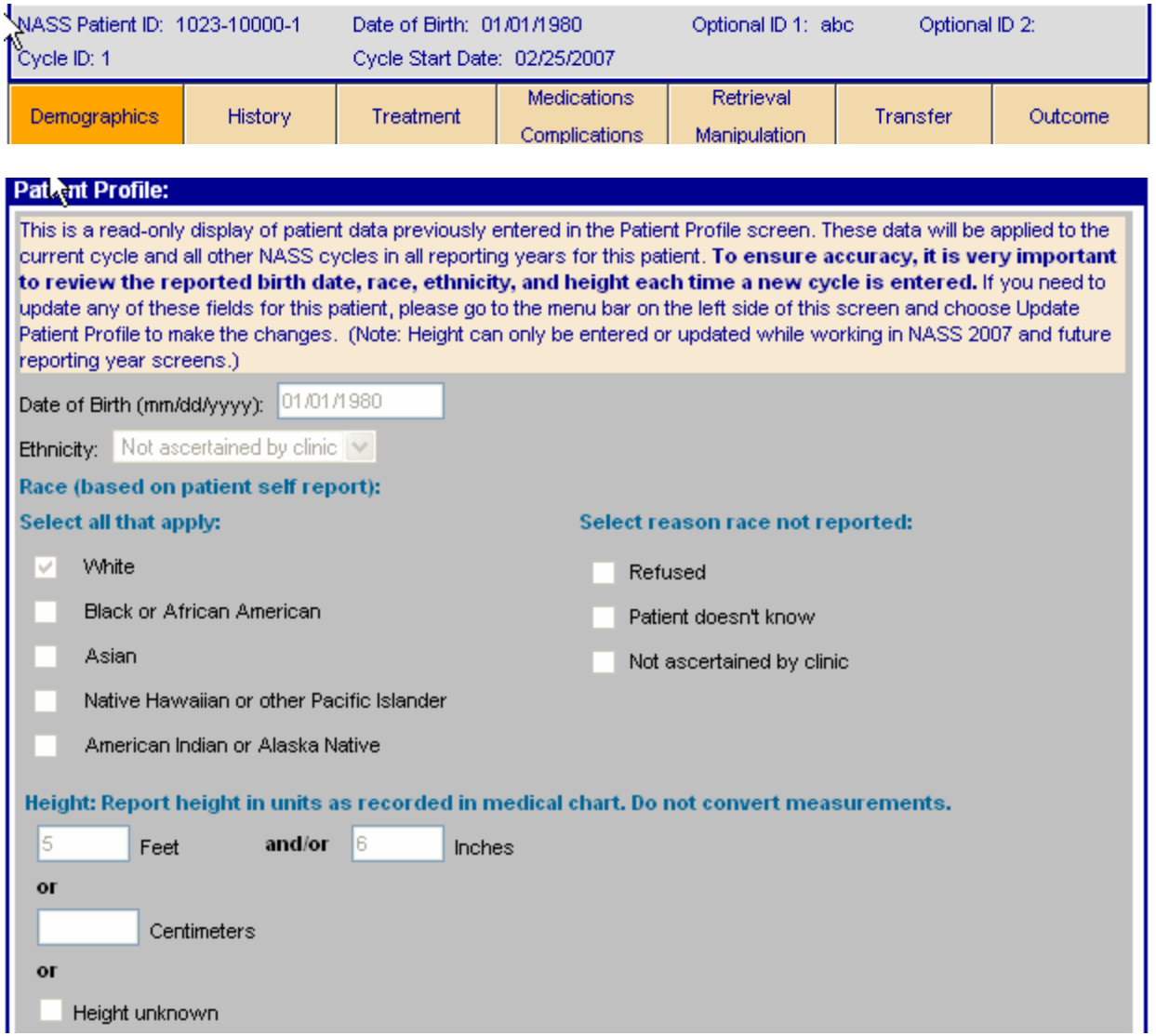
- [ ] Height unknown

Patient:

NASS Patient ID: 1023-10000-1 Date of Birth: 01/01/1980 Optional ID 1: abc Optional ID 2:

Add New Cycle

Cycle	Cycle Start Date	Cycle Complete	Delete Cycle
1	2/25/2007		Delete Cycle
2	1/5/2007		Delete Cycle
3			Delete Cycle
4	1/18/2007		Delete Cycle
5	2/14/2007		Delete Cycle
6	2/18/2007		Delete Cycle


NASS Patient ID: 1023-10000-1
Date of Birth: 01/01/1980
Optional ID 1: abc
Optional ID 2:
Cycle ID: 1
Cycle Start Date: 02/25/2007
Demographics
History
Treatment
Medications
Complications
Retrieval
Manipulation
Transfer
Outcome
Patient Profile:
This is a read-only display of patient data previously entered in the Patient Profile screen. These data will be applied to the current cycle and all other NASS cycles in all reporting years for this patient. To ensure accuracy, it is very important to review the reported birth date, race, ethnicity, and height each time a new cycle is entered. If you need to update any of these fields for this patient, please go to the menu bar on the left side of this screen and choose Update Patient Profile to make the changes. (Note: Height can only be entered or updated while working in NASS 2007 and future reporting year screens.)
Date of Birth (mm/dd/yyyy): 01/01/1980
Ethnicity: Not ascertained by clinic
Race (based on patient self report):
Select all that apply:
White
Black or African American
Asian
Native Hawaiian or other Pacific Islander
American Indian or Alaska Native
Select reason race not reported:
Refused
Patient doesn't know
Not ascertained by clinic
Height: Report height in units as recorded in medical chart. Do not convert measurements.
5
Feet
and/or
6
Inches
or
Centimeters
or
Height unknown

Patient Residency for Cycle:

Primary residence in U.S.: ---Select---

U.S. city of primary residence:

U.S. state of primary residence: ---Select---

U.S. zip code of primary residence: NOTE: Enter either 5 digits 99999 or 9 digits 99999-9999

Country of primary residence: ---Select---

Partner Race/Ethnicity:

Ethnicity: ---Select---

Race (based on patient/partner self report):

Select all that apply:

- [ ] White
- [ ] Black or African American
- [ ] Asian
- [ ] Native Hawaiian or other Pacific Islander
- [ ] American Indian or Alaska Native

Select reason race not reported:

- [ ] Refused
- [ ] Patient doesn't know
- [ ] Not ascertained by clinic

Demographics	History	Treatment	Medications Complications	Retrieval Manipulation	Transfer	Outcome

Patient History I:

Gravidity (Total number of prior pregnancies): [ ]

Number of prior full term births (>= 37 weeks):
NOTE: This includes live births and stillbirths. [ ]

Number of prior preterm births (>=20 & <37 weeks):
NOTE: This includes live births and stillbirths. [ ]

Number of prior spontaneous abortions (<20 weeks): [ ]

Surgical Sterilization-patient or partner: [---Select---]

Patient History II:

Number of prior fresh ART cycles:

Number of prior frozen ART cycles:

FSH unknown: ☐ Lab upper normal FSH unknown: ☐

Patient maximum FSH (IUs): Lab upper normal FSH (IUs):

Reason for ART (Select all that apply): NOTE: Move cursor over the choices and click on wording to show/hide definitions.

- ☐ **Male infertility**
- ☐ **History of endometriosis**
- ☐ **Tubal ligation (not reversed)**
- ☐ **Tubal disease (hydrosalpinx)**
- ☐ **Other tubal disease (not hydrosalpinx)**
- ☐ **Ovulatory disorders/PCO**
- ☐ **Diminished ovarian reserve**
- ☐ **Uterine factor**
- ☐ **Other causes of infertility**
- ☐ **Unexplained infertility**

Patient History III:

Weight at the start of this cycle:

NOTE: Report weight in units as recorded in medical chart. Do not convert measurements.

152.3 Pounds

or

Kilograms

or

☐ Weight unknown

History of cigarette smoking:

Has this patient smoked at least 100 cigarettes during entire life?

◉ Yes ○ No ○ Unknown

During the 3 months before this cycle started, did the patient smoke <u>any</u> cigarettes?

◉ Yes
○ No
○ Unknown

If patient smoked cigarettes during the 3 months before this cycle, on <u>average</u>, how many cigarettes per day did the patient <u>usually</u> smoke during those 3 months?

5 Number of cigarettes smoked per day during the 3 months before this cycle.

or

☐ Patient smoked less than 1 cigarette per day on average, during the 3 months before this cycle.
(For example, patient smoked less than 7 cigarettes per week, or smoked a couple cigarettes only on weekends.)

or

☐ Unknown how many cigarettes the patient smoked per day during the 3 months before this cycle.

MASS Patient ID: 1023-10000-1 | Date of Birth: 01/01/1980 | Optional ID 1: abc | Optional ID 2:
Cycle ID: 1 | Cycle Start Date: 02/25/2007

Demographics | History | Treatment | Medications Complications | Retrieval Manipulation | Transfer | Outcome

Treatment Detail:

NOTE: This section must be completed for all cycles started. All responses must be based on ***intention*** to treat at cycle start.

Date current cycle started (mm/dd/yyyy): 02/25/2007

Embryo or oocyte banking cycle: ○ Yes ◉ No

NOTE: Banking cycles include cycles initiated with the intent of cryopreserving ALL embryos or oocytes for later use.

Oocyte/Embryo Source (Select an answer for each source listed):

Yes	No	
○	◉	**PATIENT:** Intent to use patient's oocytes/embryos, fertilized with partner or donor sperm
◉	○	**DONOR OOCYTE:** Intent to use oocytes from donor
◉	○	**DONOR EMBRYO:** Intent to use embryos donated from another couple's ART

Oocyte/Embryo State (Select an answer for each state listed):

Yes	No	
○	◉	**FRESH:** Intent to transfer fresh oocytes/embryos retrieved during this cycle
◉	○	**FROZEN:** Intent to transfer thawed embryos from a previous cycle

Intended Transfer Method (Select all that apply):

☑ **IVF:** Transcervical ☐ **GIFT:** Gametes to tubes ☐ **ZIFT:** Zygotes to tubes or **TET:** Tubal embryo transfer

Gestational carrier: ○ Yes ◉ No

Treatment Detail: Date of Birth for Donor and/or Gestational Carrier

Answer if oocyte/embryo source is DONOR:

Enter donor date of birth (mm/dd/yyyy):
Note: If multiple donors, enter birth date of **youngest** donor.

[ ] Donor date of birth

If donor date of birth cannot be reported, provide donor age at earliest time donor oocytes were retrieved:
Note: If multiple donors, enter age of **youngest** donor.

[ ] Donor age at retrieval

or

[x] Unknown birth date and age of donor

Answer if GESTATIONAL CARRIER is used:

Enter gestational carrier date of birth (mm/dd/yyyy):

[ ] Gestational carrier date of birth

or

[ ] Unknown gestational carrier date of birth

Special Techniques Applicable To Current Cycle:

Select all that apply:

- [ ] Round spermatid nucleic injection (ROSNI)
- [ ] Cytoplasmic transfer
- [ ] IMMATURE oocyte retrieval & fertilization OR thawing IMMATURE fertilized oocytes, with intent to transfer in current cycle
- [x] Device study
- [ ] Protocol study
- [ ] Pharmacological study
- [ ] Other research

NASS Patient ID: 1023-10000-1 | Date of Birth: 01/01/1980 | Optional ID 1: abc | Optional ID 2:

Cycle ID: 1 | Cycle Start Date: 02/25/2007

Patient Medication:

Patient medicated to stimulate follicular development: ○ Yes ○ No

Medications containing clomiphene: ○ Yes ○ No

Clomiphene dosage (Total mgs):

Medications containing FSH: ○ Yes ○ No

FSH medication dosage (Total IUs):

GnRH Protocol (Select only one, if applicable):

- ☐ GnRH Agonist Suppression
- ☐ GnRH Agonist Flare
- ☐ GnRH Antagonist Suppression

Donor Medication:

Donor medicated to stimulate follicular development: ○ Yes ○ No

Donor medications containing clomiphene: ○ Yes ○ No

Donor clomiphene dosage (Total mgs):

Donor medications containing FSH: ○ Yes ○ No

Donor FSH medication dosage (Total IUs):

Donor GnRH Protocol (Select only one, if applicable):

- ☐ GnRH Agonist Suppression
- ☐ GnRH Agonist Flare
- ☐ GnRH Antagonist Suppression

Complications:

Complications related to ART (Select all that apply):

- [ ] Infection
- [ ] Hemorrhage
- [ ] Moderate ovarian hyperstimulation
- [ ] Severe ovarian hyperstimulation
- [ ] Medication side effect
- [ ] Anesthetic complication
- [ ] Psychological stress
- [ ] Death of patient
- [ ] Other
- [ ] None

Hospitalization related to a complication: ---Select---

Canceled Cycle Data:

Cycle canceled before oocyte retrieval: ○ Yes ◉ No Date cycle canceled (mm/dd/yyyy):

Select reason cycle was canceled: ---Select---

Demographics	History	Treatment	Medications Complications	Retrieval Manipulation	Transfer	Outcome

Patient Retrieval Data: Fresh

Date patient oocyte retrieval performed (mm/dd/yyyy):

Number of patient oocytes retrieved:

Patient Retrieval Data: Frozen/Thawed

Enter date patient oocytes were retrieved from previous cycle for use in current frozen/thawed cycle (mm/dd/yyyy): Retrieval date **or** Date unknown

Note: If multiple frozen/thawed patient embryos were used, enter the retrieval date from the earliest cycle.

Donor Retrieval Data: Fresh

Date donor oocyte retrieval performed (mm/dd/yyyy):

Note: If multiple donors were used, enter the retrieval date that corresponds to the **youngest** donor.

Number of donor oocytes retrieved:

Were donor oocytes shared with multiple patients? Yes No

Donor Retrieval Data: Frozen/Thawed

Enter date donor oocytes were retrieved from previous cycle for use in current frozen/thawed cycle (mm/dd/yyyy): 03/15/2007 Retrieval date **or** Date unknown

Note: If multiple frozen/thawed donor embryos were used, enter the retrieval date that corresponds to the **youngest** donor.

Semen Information:

Source of semen used for fertilization: ---Select---

Choose the method for obtaining semen: ---Select---

Manipulation Techniques:

Intracytoplasmic sperm injection (ICSI) performed on oocytes:

- ○ Yes
- ○ No
- ○ Unknown because embryos thawed from previous cycle

Assisted hatching performed on embryos:

- ○ Yes
- ○ No

Pre-implantation genetic diagnosis or screening performed on embryos:

- ○ Yes
- ○ No
- ○ Unknown because embryos thawed from previous cycle

Pre-implantation genetic diagnosis or screening reason (Select all that apply):

- ☐ Either genetic parent is a known carrier of a gene mutation or a chromosomal abnormality
- ☐ Aneuploidy screening of the embryos
- ☐ Other screening of the embryos
- ☐ Unknown

Previous Screen | Next Screen | Save Data

Demographics | History | Treatment | Medications Complications | Retrieval Manipulation | **Transfer** | Outcome

General Transfer Information:

Transfer of embryos or oocytes attempted even if no embryos transferred: (•) Yes ( ) No

Date of transfer (mm/dd/yyyy): 03/21/2007

Embryos Thawed:

Number of embryos **THAWED** with intent to transfer: 5

UTERINE Transfers:

Number of **FRESH** embryos transferred to uterus:

Number of **THAWED** embryos transferred to uterus: 2

UTERINE Transfer Detail:

Were **any** of the fresh or thawed embryos transferred to the uterus with ultrasound guidance?

(•) Yes ( ) No ( ) Unknown [Clear Answer]

Answer the following question if a total of only one embryo was transferred to the uterus during this cycle (regardless if ultrasound guidance was used):

If **only one** embryo was transferred to the uterus, was this an elective single embryo transfer?

( ) Yes ( ) No ( ) Unknown [Clear Answer]

FALLOPIAN TUBE Transfers:

	FRESH Transfers to Fallopian Tubes:	THAWED Transfers to Fallopian Tubes:
Number of OOCYTES:		
Number of EMBRYOS:		

ZIFT and TET Transfer Details:

Answer the following question if a total of only one embryo was transferred to the fallopian tubes during this cycle using ZIFT or TET:

If **only one** embryo was transferred to the fallopian tubes using ZIFT or TET, was this an elective single embryo transfer?

○ Yes ○ No ○ Unknown Clear Answer

CRYOPRESERVATION:

Number of FRESH embryos cryopreserved:	
Number of THAWED embryos cryopreserved (re-frozen):	

Demographics | History | Treatment | Medications Complications | Retrieval Manipulation | Transfer | Outcome

Treatment Outcome:

Outcome of treatment cycle: Clinical intrauterine gestation

If pregnant, was ultrasound performed: ○ Yes ◉ No

Date ultrasound with max. number of fetal hearts observed (mm/dd/yyyy):

Maximum fetal hearts on ultrasound prior to reduction, if any:

Pregnancy Outcome:

Outcome of pregnancy: Live birth

Date of pregnancy outcome (mm/dd/yyyy):

NOTE: If multiple births cover more than one date, enter date of first born.

Source of information confirming pregnancy outcome:

Written confirmation, physician or hospital

Number of infants born: 2 NOTE: This number includes live-born and stillborn infants.

Birth Section:

No births currently reported for this cycle.

Birth #	Birth Outcome	Gender	Pounds	Ounces	Grams	Weight unknown
1	Live birth	---Select---	lbs	oz	g	☐
2	Stillbirth	---Select---	lbs	oz	g	☐

NOTE: Enter either pounds and ounces, or grams

Cycle Complete:

Please check this box to indicate that data entry is complete for this patient cycle: ☐