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**National ART Surveillance System
NASS 2.0
(Proposed for 2016)**

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INITIAL REPORTING: PATIENT PROFILE (PROSPECTIVE)	
Quex ID	LEAD QUESTION
1	Date of cycle reporting (mm/dd/yyyy): _ _ - _ _ - _ _ _ _
2	NASS Patient ID: _ _ _ _ - _ _ _ _ - _ _
3	Patient Optional Identifiers Optional Identifier 1 _ _ _ _ _ _ _ _ maximum 7 digits or characters Optional Identifier 2 _ _ _ _ _ _ _ _ maximum 7 digits or characters
4	Patient Date of Birth (mm/dd/yyyy): _ _ - _ _ - _ _ _ _
5	Sex of patient: <input type="radio"/> Male <input type="radio"/> Female
6	Cycle Start Date _ _ - _ _ - _ _ _ _
RESIDENCY	
7	At the start of the cycle, is patient residency primarily in U.S.? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Refused
7A	U.S. state of primary residence: <input type="text"/> City of primary residence <input type="text"/> U.S. zip code at primary residence _ _ _ _ _ OR Country of primary residence: <input type="text"/>
INTENT	
8	Intended type of ART? Select all that apply: <input type="checkbox"/> IVF: Transcervical <input type="checkbox"/> GIFT: Gametes to tubes <input type="checkbox"/> ZIFT: Zygotes to tubes or TET: tubal embryo transfer <input type="checkbox"/> Oocyte or embryo banking
9	If cycle is for banking only, specify banking type (select all that apply): <input type="checkbox"/> Embryo banking <input type="checkbox"/> Autologous oocyte banking <input type="checkbox"/> Donor oocyte banking
9A	Indicate anticipated duration of oocyte banking SKIP IF EMBRYO BANKING ONLY <input type="checkbox"/> Short term (<12 months) <input type="checkbox"/> Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments <input type="checkbox"/> Long term (≥12 months) banking for other reasons
9B	Indicate anticipated duration of embryo banking SKIP IF OOCYTE BANKING ONLY <input type="checkbox"/> Short term (<12 months) <input type="checkbox"/> Delay of transfer to obtain genetic information <input type="checkbox"/> Delay of transfer for other reasons <input type="checkbox"/> Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments <input type="checkbox"/> Long term (≥12 months) banking for other reasons
10	Intended embryo source (select all that apply): [IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #12] <input type="checkbox"/> Patient embryos <input type="checkbox"/> Donor embryos <input type="checkbox"/> Fresh embryos <input type="checkbox"/> Frozen embryos
10A	If intent is to use FRESH EMBRYOS, specify intended oocyte source. Select all that apply: <input type="checkbox"/> Fresh patient oocytes <input type="checkbox"/> Frozen patient oocytes <input type="checkbox"/> Fresh donor oocytes <input type="checkbox"/> Frozen donor oocytes

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	<p>If intent is to use FROZEN EMBRYOS, specify intended oocyte source. Select all that apply:</p> <input type="checkbox"/> Fresh patient oocytes <input type="checkbox"/> Frozen patient oocytes
	<input type="checkbox"/> Fresh donor oocytes <input type="checkbox"/> Frozen donor oocytes <input type="checkbox"/> Unknown (select only if oocyte source is unknown)
10B	<p>If intent is to use donor embryos (select all that apply):</p> <input type="checkbox"/> Fresh embryos <input type="checkbox"/> Frozen embryos
11	<p>Specify intended sperm source. Select all that apply. [SKIP IF DONOR EMBRYO IS INTENDED SOURCE]</p> <input type="checkbox"/> Partner <input type="checkbox"/> Donor <input type="checkbox"/> Patient, if male <input type="checkbox"/> Unknown (select only if <u>all</u> sperm sources unknown for frozen)
12	<p>Pregnancy carrier</p> <input type="checkbox"/> Patient <input type="checkbox"/> Gestational carrier <input type="checkbox"/> None (oocyte or embryo banking cycle only)

CYCLE INFORMATION (NOT PROSPECTIVE FROM HERE FORWARD)

Quex ID	LEAD QUESTION
13	<p>Type of ART performed? Select all that apply:</p> <input type="checkbox"/> IVF: Transcervical <input type="checkbox"/> GIFT: Gametes to tubes <input type="checkbox"/> ZIFT: Zygotes to tubes or TET: tubal embryo transfer <input type="checkbox"/> Oocyte or embryo banking
14	<p>Embryo source (select all that apply): [IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #15]</p> <input type="checkbox"/> Patient embryos <input type="checkbox"/> Donor embryos <input type="checkbox"/> Fresh embryos <input type="checkbox"/> Frozen embryos
14A	<p>If FRESH EMBRYOS were used, specify intended oocyte source. Select all that apply:</p> <input type="checkbox"/> Fresh patient oocytes <input type="checkbox"/> Frozen patient oocytes <input type="checkbox"/> Fresh donor oocytes <input type="checkbox"/> Frozen donor oocytes <p>If FROZEN EMBRYOS were used, specify intended oocyte source. Select all that apply:</p> <input type="checkbox"/> Fresh patient oocytes <input type="checkbox"/> Frozen patient oocytes <input type="checkbox"/> Fresh donor oocytes <input type="checkbox"/> Frozen donor oocytes <input type="checkbox"/> Unknown (select only if oocyte source is unknown)

PATIENT MEDICAL EVALUATION

REASON FOR ART			
Quex ID	LEAD QUESTION		
15	<p>Reason for ART (Select all that apply):</p> <input type="checkbox"/> Male infertility (select all that apply)		
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; vertical-align: top;"> <p>[SKIP IF MALE INFERTILITY NOT SELECTED]</p> </td> <td> <input type="checkbox"/> Medical condition <input type="checkbox"/> Genetic or chromosomal abnormality Specify _____ <input type="checkbox"/> Abnormal sperm parameters (select all that apply) <input type="checkbox"/> Azoospermia, obstructive <input type="checkbox"/> Azoospermia, non-obstructive <input type="checkbox"/> Oligospermia, severe (<5 million/mL) <input type="checkbox"/> Oligospermia, moderate (5-15 million/mL) <input type="checkbox"/> Low motility (<40%) <input type="checkbox"/> Low morphology (4%) <input type="checkbox"/> Other male factor (not included above) Specify _____ </td> </tr> </table>	<p>[SKIP IF MALE INFERTILITY NOT SELECTED]</p>	<input type="checkbox"/> Medical condition <input type="checkbox"/> Genetic or chromosomal abnormality Specify _____ <input type="checkbox"/> Abnormal sperm parameters (select all that apply) <input type="checkbox"/> Azoospermia, obstructive <input type="checkbox"/> Azoospermia, non-obstructive <input type="checkbox"/> Oligospermia, severe (<5 million/mL) <input type="checkbox"/> Oligospermia, moderate (5-15 million/mL) <input type="checkbox"/> Low motility (<40%) <input type="checkbox"/> Low morphology (4%) <input type="checkbox"/> Other male factor (not included above) Specify _____
<p>[SKIP IF MALE INFERTILITY NOT SELECTED]</p>	<input type="checkbox"/> Medical condition <input type="checkbox"/> Genetic or chromosomal abnormality Specify _____ <input type="checkbox"/> Abnormal sperm parameters (select all that apply) <input type="checkbox"/> Azoospermia, obstructive <input type="checkbox"/> Azoospermia, non-obstructive <input type="checkbox"/> Oligospermia, severe (<5 million/mL) <input type="checkbox"/> Oligospermia, moderate (5-15 million/mL) <input type="checkbox"/> Low motility (<40%) <input type="checkbox"/> Low morphology (4%) <input type="checkbox"/> Other male factor (not included above) Specify _____		

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		<input type="checkbox"/> History of endometriosis <input type="checkbox"/> Tubal ligation for contraception <input type="checkbox"/> Current or prior hydrosalpinx
	[SKIP IF HYDROSALPINX NOT SELECTED]	<input type="checkbox"/> Communicating <input type="checkbox"/> Occluded <input type="checkbox"/> Unknown
		<input type="checkbox"/> Other tubal disease (not current or historic hydrosalpinx) <input type="checkbox"/> Ovulatory disorders
	[SKIP IF OVULATORY DISORDER NOT SELECTED]	<input type="checkbox"/> PCO <input type="checkbox"/> Other ovulatory disorders
		<input type="checkbox"/> Diminished ovarian reserve <input type="checkbox"/> Uterine factor <input type="checkbox"/> Preimplantation Genetic Diagnosis as primary reason for ART <input type="checkbox"/> Oocyte or Embryo Banking as reason for ART <input type="checkbox"/> Indication for use of gestational carrier
	[SKIP IF GESTATIONAL CARRIER NOT INDICATED]	<input type="checkbox"/> Absence of uterus <input type="checkbox"/> Significant uterine anomaly <input type="checkbox"/> Medical contraindication to pregnancy <input type="checkbox"/> Recurrent pregnancy loss <input type="checkbox"/> Unknown
		<input type="checkbox"/> Recurrent pregnancy loss <input type="checkbox"/> Other reasons related to infertility (specify) _____ <input type="checkbox"/> Other reasons <u>not</u> related to infertility (specify) _____ <input type="checkbox"/> Unexplained infertility
FEMALE PATIENT HISTORY AND PHYSICAL		
16		[IF SEX OF PATIENT = MALE (FROM QUESTION #5) THEN SKIP #16-23] Height: _ _ Feet and/or _ _ Inches or _ _ _ _ Centimeters or <input type="checkbox"/> Height unknown
17		Weight at the start of this cycle _ _ _ _ Pounds or _ _ _ _ Kilograms or <input type="checkbox"/> Weight unknown
18		History of cigarette smoking: Did the patient smoke during the 3 months before the cycle started? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19		Any prior pregnancies? <input type="radio"/> Yes <input type="radio"/> No
19A		[SKIP IF NO PRIOR PREGNANCIES] If prior pregnancies reported and couple is not surgically sterile, enter months or years attempting pregnancy since last clinical pregnancy _ _ _ months and/or _ _ years [SKIP IF ANY PRIOR PREGNANCIES] If no prior pregnancies reported and couple is not surgically sterile, enter months attempting pregnancy _ _ _ months and/or _ _ years
19B	SKIP IF NO PRIOR	If prior pregnancies reported, how many _ _

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19C	PREGNANCIES	Number of prior full term births __ __
19D		Number of prior preterm births __ __
19E		Number of prior stillbirths __ __
19F		Number of prior spontaneous abortions __ __
19G		Number of ectopic pregnancies __ __
20	Number of prior stimulations for ART: __ __	
21	Number of prior frozen ART cycles: __ __	
21A	SKIP IF NO PRIOR ART CYCLES	Did any of the prior ART cycles result in a live birth? <input type="radio"/> Yes <input type="radio"/> No
22	Patient maximum FSH level (MIU/mls): __ __ __ . __ __ Or FSH unknown: <input type="checkbox"/>	
23	Most recent AMH level (ng/mL): __ __ __ . __ __ Or AMH unknown: <input type="checkbox"/> Date of most recent AMH level __ __ - __ __ - __ __ __ __	
SOURCE AND CARRIER PROFILES		
OOCYTE SOURCE PROFILE		
Quex ID	LEAD QUESTION	
24A	[IF OOCYTE SOURCE = PATIENT AND DONOR, ANSWER THIS QUESTION] Youngest oocyte source <input type="checkbox"/> Patient [SKIP TO Q25] <input type="checkbox"/> Donor [CONTINUE TO Q24]	
24B	OOCYTE SOURCE Date of Birth (mm/dd/yyyy): [FIELD PRE-FILLED IF OOCYTE SOURCE=PATIENT] __ __ - __ __ - __ __ __ __ OR age at earliest time oocytes were retrieved ____	
25	OOCYTE SOURCE Ethnicity: Select one: <input type="checkbox"/> NOT Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Refused <input type="checkbox"/> Unknown	
26	OOCYTE SOURCE Race (based on oocyte source self-report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native	
26A	Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown	
PREGNANCY CARRIER PROFILE		
27	Pregnancy carrier <input type="checkbox"/> Patient <input type="checkbox"/> Gestational carrier <input type="checkbox"/> None (oocyte or embryo banking cycle only)	

28	<p>[IF CARRIER=NONE THEN SKIP 28-31] or [IF CARRIER=PATIENT AND OOCYTE SOURCE=PATIENT THEN SKIP 28-31]</p> <p>Pregnancy carrier Date of Birth (mm/dd/yyyy): _ _ - _ _ - _ _ _ _ _ OR age at time of transfer ____</p>	
29	<p>Pregnancy carrier Ethnicity: Select one: <input type="radio"/> NOT Hispanic or Latino <input type="radio"/> Hispanic or Latino <input type="radio"/> Refused <input type="radio"/> Unknown</p>	
30	<p>Pregnancy carrier Race (based on gestational carrier self report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native</p>	
30A	<p>Yes</p>	<p>Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown</p>
Quex ID	LEAD QUESTION	
	SPERM SOURCE PROFILE	
31	<p>Specify sperm source. Select all that apply. <input type="checkbox"/> Partner <input type="checkbox"/> Donor <input type="checkbox"/> Patient, if male <input type="checkbox"/> Unknown (select only if <u>all</u> sperm sources unknown for frozen)</p>	
32	<p>SPERM source Date of Birth (mm/dd/yyyy): _ _ - _ _ - _ _ _ _ _ [FIELD PRE-FILLED IF SPERM SOURCE=MALE PATIENT] Or <input type="checkbox"/> Unknown</p>	
33	<p>SPERM source Ethnicity: Select one: <input type="radio"/> NOT Hispanic or Latino <input type="radio"/> Hispanic or Latino <input type="radio"/> Refused <input type="radio"/> Unknown</p>	
34	<p>SPERM source Race (based on patient self report) Select all that apply: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native</p>	
34A		<p>Select reason race not reported: <input type="radio"/> Refused <input type="radio"/> Unknown</p>
	STIMULATION AND RETRIEVAL	
Quex ID	LEAD QUESTION	
	OVARIAN STIMULATION AND MEDICATIONS	
35	<p>Was there stimulation for follicular development? [IF NO STIMULATION OR FROZEN CYCLE, SKIP #36-39] <input type="radio"/> Yes <input type="radio"/> No</p>	

	Was this a minimal stimulation cycle? <input type="radio"/> Yes <input type="radio"/> No	
36	Oral medication such as aromatase inhibitor or selective estrogen receptor modulator? <input type="radio"/> Yes <input type="radio"/> No	
36A	[SKIP IF NO ORAL MEDS]	Clomiphene dosage (Total mgs): _ _ _ _ _ _ . _ _ _ Letrozole dosage (Total mgs) _ _ _ _ _ _ . _ _ _ Other (specify) _____ dosage _ _ _ _ _ _ . _ _ _
37	Medication(s) containing FSH? <input type="radio"/> Yes <input type="radio"/> No	
37A	[SKIP IF NO FSH MEDS]	Short-acting FSH (Total IUs): _ _ _ _ _ _ . _ _ _
37B		Long-acting FSH (Total mgs): _ _ _ _ _ _ . _ _ _
38	Medication(s) with LH/HCG activity? <input type="radio"/> Yes <input type="radio"/> No	
Quex ID	LEAD QUESTION	
39	GnRH Protocol Select the one <u>primary</u> protocol: <input type="radio"/> No GnRH protocol <input type="radio"/> GnRH Agonist Suppression <input type="radio"/> GnRH Agonist Flare <input type="radio"/> GnRH Antagonist Suppression	
CANCELLATION-I (open only for fresh cycles)		
40	[IF OOCYTE/EMBRYO SOURCE = FROZEN THEN SKIP 40-45] Was this ART cycle canceled prior to retrieval? <input type="radio"/> Yes <input type="radio"/> No	
40A	[SKIP IF CYCLE NOT CANCELLED]	Date cycle canceled (mm/dd/yyyy): _ _ - _ _ - _ _ _ _ _
40B		Select one primary reason cycle was canceled: <input type="checkbox"/> Low ovarian response <input type="checkbox"/> High ovarian response <input type="checkbox"/> Inadequate endometrial response <input type="checkbox"/> Concurrent illness <input type="checkbox"/> Withdrawal only for personal reasons <input type="checkbox"/> OTHER - specify _____
[IF CYCLE CANCELLED, STOP HERE]		
FRESH OOCYTE RETRIEVAL		
41	Date retrieval performed (mm/dd/yyyy): _ _ - _ _ - _ _ _ _ _	
42	Total number of patient oocytes retrieved: _ _ _	
43	Total number of donor oocytes retrieved: _ _ _	
44	Use of <u>retrieved</u> oocytes Select all that apply: <input type="checkbox"/> Used for this cycle <input type="checkbox"/> Oocytes frozen for future use <input type="checkbox"/> Oocytes shared with other patients <input type="checkbox"/> Embryos frozen for future use	
44A	[SKIP IF NO OOCYTES FROZEN]	Number of FRESH oocytes frozen for future use: _ _ _
COMPLICATIONS OF OVARIAN STIMULATION OR OOCYTE RETRIEVAL		
45	Were there any complications of ovarian stimulation or oocyte retrieval? <input type="radio"/> Yes <input type="radio"/> No	

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45A	SKIP IF NO COMPLICATIONS	<p>Select all complications that apply:</p> <p><input type="checkbox"/> Infection</p> <p><input type="checkbox"/> Hemorrhage requiring transfusion</p> <p><input type="checkbox"/> Ovarian hyperstimulation requiring intervention or hospitalization</p> <p><input type="checkbox"/> Medication side effect</p> <p><input type="checkbox"/> Anesthetic complication</p> <p><input type="checkbox"/> Thrombosis</p> <p><input type="checkbox"/> Death of patient</p> <p><input type="checkbox"/> Other - specify _____</p>
45B	SKIP IF NO COMPLICATIONS	<p>Did the complication(s) require hospitalization?</p> <p style="text-align: center;"><input type="radio"/> Yes <input type="radio"/> No</p>
[IF OOCYTE BANKING CYCLE <u>ONLY</u>, STOP HERE]		

SPERM RETRIEVAL	
46	<p>Sperm status:</p> <input type="checkbox"/> Fresh <input type="checkbox"/> Thawed <input type="checkbox"/> Mix of fresh and thawed
47	<p>Sperm source utilized:</p> <input type="radio"/> Ejaculated <input type="radio"/> Epididymal <input type="radio"/> Testis <input type="radio"/> Electroejaculation <input type="radio"/> Retrograde urine <input type="radio"/> Donor <input type="radio"/> Unknown
LABORATORY INFORMATION	
Quex ID	LEAD QUESTION
MANIPULATION	
48	<p>Intracytoplasmic sperm injection (ICSI) performed on oocytes?</p> <input type="radio"/> All oocytes <input type="radio"/> Some oocytes <input type="radio"/> No oocytes <input type="radio"/> Unknown
48A	<p>SKIP IF NO ICSI</p> <p>Indication for ICSI (select all that apply)</p> <input type="radio"/> Prior failed fertilization <input type="radio"/> Poor fertilization <input type="radio"/> PGD <input type="radio"/> Abnormal semen parameters on day of fertilization <input type="radio"/> Low oocyte yield <input type="radio"/> Laboratory routine <input type="radio"/> Frozen cycle <input type="radio"/> Rescue ICSI <input type="radio"/> Other - specify _____
49	<p>In vitro maturation (IVM) performed on oocytes?</p> <input type="radio"/> All oocytes <input type="radio"/> Some oocytes <input type="radio"/> No oocytes <input type="radio"/> Unknown
50	<p>Pre-implantation genetic diagnosis or screening performed on embryos?</p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
50A	<p>Total number of 2PN: __ __ </p>
50B	<p>Reason(s) for pre-implantation genetic diagnosis or screening (Select all that apply):</p> <input type="checkbox"/> Either genetic parent is a known carrier of a gene mutation or a chromosomal abnormality <input type="checkbox"/> Aneuploidy screening of the embryos <input type="checkbox"/> Elective Gender Determination <input type="checkbox"/> Other screening of the embryos
50C	<p>Technique(s) used for pre-implantation genetic diagnosis or screening (Select all that apply):</p> <input type="checkbox"/> Polar Body Biopsy <input type="checkbox"/> Blastomere Biopsy <input type="checkbox"/> Blastocyst Biopsy <input type="checkbox"/> Unknown
51	<p>Assisted hatching performed on embryos?</p> <input type="radio"/> All embryos <input type="radio"/> Some embryos <input type="radio"/> No embryos <input type="radio"/> Unknown

52	Was this a research cycle? <input type="radio"/> Yes Enter SART approval code _____ <input type="radio"/> No	
52A	SKIP IF NOT RESEARCH CYCLE	Study type: <input type="checkbox"/> Device study <input type="checkbox"/> Protocol study <input type="checkbox"/> Pharmaceutical study <input type="checkbox"/> Laboratory technique <input type="checkbox"/> Other research
		If 'Other', please specify _____
[IF EMBRYO BANKING CYCLE ONLY, SKIP TO #59, THEN STOP]		
TRANSFER		
Quex ID	LEAD QUESTION	
	CANCELLATION-II	
53	Was a transfer attempted? <input type="radio"/> Yes <input type="radio"/> No	
53A		Select one primary reason no transfer was attempted: <input type="checkbox"/> Low ovarian response <input type="checkbox"/> High ovarian response <input type="checkbox"/> Failure to survive oocyte thaw <input type="checkbox"/> Inadequate endometrial response <input type="checkbox"/> Concurrent illness <input type="checkbox"/> Withdrawal only for personal reasons <input type="checkbox"/> Unable to obtain sperm specimen <input type="checkbox"/> Insufficient embryos <input type="checkbox"/> OTHER - specify _____
[IF TRANSFER NOT ATTEMPTED, STOP HERE]		
GENERAL TRANSFER DETAILS		
54	Date of embryo transfer (mm/dd/yyyy): __ __ - __ __ - __ __ __ __	
55	Endometrial thickness at trigger: __ __ mm	
FRESH EMBRYO TRANSFER DETAILS		
56	[IF NO FRESH EMBRYOS TRANSFERRED, SKIP #57-58] Number of FRESH embryos transferred to uterus: __ __	
57	[SKIP #57 FOR MIXED CYCLE] If only <u>one</u> fresh embryo was transferred to the uterus, was this an <u>elective</u> single embryo transfer? <input type="radio"/> Yes <input type="radio"/> No	
58A-X	Quality of embryo #1-X <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unknown	
	Date of oocyte retrieval for embryo #1-X __ __ - __ __ - __ __ __ __	
59	Number of FRESH embryos cryopreserved: __ __ [STOP HERE FOR EMBRYO BANKING ONLY CYCLE]	
THAWED EMBRYO TRANSFER DETAILS		
60	Number of FROZEN or THAWED embryos available on day of transfer: __ __	
61	Number of THAWED embryos transferred to uterus: __ __ [IF NO THAWED EMBRYOS TRANSFERRED, SKIP #62]	

62	<p>[SKIP #63 FOR MIXED CYCLE] If only <u>one</u> thawed embryo was transferred to the uterus, was this an <u>elective</u> single embryo transfer? <input type="radio"/> Yes <input type="radio"/> No</p>	
62A-X	<p>Quality of embryo #1-X <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Unknown</p>	
	<p>Date of oocyte retrieval for embryo #1-X __ _ - __ _ - __ _ _ _ </p>	
63	<p>Number of THAWED embryos cryopreserved (re-frozen): __ _ </p>	
<p>GIFT/ZIFT/TET TRANSFER DETAILS</p>		
64	<p>[SKIP IF IVF CYCLE] Number of oocytes or embryos transferred to the FALLOPIAN TUBE: __ _ </p>	
<p>TREATMENT OUTCOME (only opens if transfer >0)</p>		
Quex ID	LEAD QUESTION	
	<p>OUTCOME OF TRANSFER</p>	
65	<p>Outcome of treatment cycle: <input type="checkbox"/> Not pregnant <input type="checkbox"/> Biochemical only <input type="checkbox"/> Clinical intrauterine gestation <input type="checkbox"/> Ectopic <input type="checkbox"/> Heterotopic <input type="checkbox"/> Unknown</p> <p>[IF NOT PREGNANT, BIOCHEMICAL ONLY, ECTOPIC, OR HETEROTOPIC, STOP HERE]</p>	
66	<p>Maximum fetal hearts on ultrasound performed before 7 weeks or prior to reduction: __ _ <input type="checkbox"/> No ultrasound performed before 7 weeks gestation</p>	
66A	[SKIP IF NO U/S]	<p>Date ultrasound with max. number of fetal hearts observed before 7 weeks (mm/dd/yyyy): __ _ - __ _ - __ _ _ _ </p>
66B	[SKIP IF NO U/S]	<p>If 2 or more fetal hearts, any monochorionic twins or multiples? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown</p>
<p>PREGNANCY OUTCOME (only opens if pregnancy = yes)</p>		
Quex ID	LEAD QUESTION	
	<p>OUTCOME OF PREGNANCY</p>	
67	<p>Outcome of pregnancy: <input type="checkbox"/> Live birth <input type="checkbox"/> Spontaneous abortion <input type="checkbox"/> Stillbirth <input type="checkbox"/> Induced abortion <input type="checkbox"/> Maternal death prior to birth <input type="checkbox"/> Outcome unknown</p>	
68	<p>Date of pregnancy outcome (mm/dd/yyyy): __ _ - __ _ - __ _ _ _ NOTE: If multiple births cover more than one date, enter date of first born.</p>	
68A	<p>Method of delivery <input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean section</p>	
69	<p>Source of information confirming pregnancy outcome: (Select all that apply) <input type="checkbox"/> Verbal confirmation from patient <input type="checkbox"/> Written confirmation from patient <input type="checkbox"/> Verbal confirmation from physician or hospital</p>	

	<input type="checkbox"/> Written confirmation from physician or hospital
BIRTH INFORMATION	
70	Number of infants born: _ _
71A-X	Birth Status infant #1-X <input type="checkbox"/> Live birth <input type="checkbox"/> Stillbirth <input type="checkbox"/> Unknown
72A-X	Gender infant #1-X <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
73A-X	Weight in pounds and ounces, or grams infant #1-X _ _ lbs and _ _ oz. OR _ _ _ _ g OR <input type="checkbox"/> Weight unknown
74A-X	Birth defects (select all that apply) infant #1-X <input type="checkbox"/> None <input type="checkbox"/> Cleft lip/palate <input type="checkbox"/> Genetic defect/chromosomal abnormality <input type="checkbox"/> Neural tube defect <input type="checkbox"/> Cardiac defect <input type="checkbox"/> Limb defect <input type="checkbox"/> Other (specify) OR <input type="checkbox"/> Unknown