National ART Surveillance System
NASS 2.0

DRAFT

INITIAL REPORTING		
		PATIENT PROFILE
Date	1	**Date of cycle reporting** |__|__| - |__|__| - |__|__|__|__|
Pre-fill	2	**NASS patient ID** |__|__|__|__| - |__|__|__|__| - |__|__|
Text		**Patient optional identifiers** Optional identifier 1 |__|__|__|__|__|__|__| Maximum 7 numbers or letters Optional identifier 2 |__|__|__|__|__|__|__| Maximum 7 numbers or letters
Date	4	**Patient date of birth (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__|
Radio	5	**Sex of patient** ◯ Female ◯ Male
Drop-down	5A	**Patient ethnicity** ◯ NOT Hispanic or Latino ◯ Hispanic or Latino ◯ Refused ◯ Unknown
Checkbox (MR)	5B	**Patient race (select all that apply)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native Or
Drop-down	5C	**Reason race not reported** ◯ Refused ◯ Unknown
Date		**Cycle start date**|__|__| - |__|__| - |__|__|__|__|
		RESIDENCY
Radio	7	**At the start of cycle, is patient residency primarily in U.S.?** ◯ Yes ◯ No ◯ Refused
Drop-down	7A	**U.S. city of primary residence**
Drop-down		**U.S. state of primary residence**
Text		**U.S. zip code of primary residence** |__|__|__|__|__|
Drop-down		Or

		Country of primary residence	
		INTENT	
Checkbox (MR + SR)		**Intended type of ART (select all that apply)** ☐ IVF: Transcervical ☐ GIFT: Gametes to tubes ☐ ZIFT: Zygotes to tubes or TET: tubal embryo transfer Or ☐ Oocyte or embryo banking	
Checkbox (MR)		**[SKIP IF NOT A BANKING ONLY CYCLE]**	**Banking type (select all that apply)** ☐ Embryo banking ☐ Autologous oocyte banking ☐ Donor oocyte banking
Checkbox (MR)			**Intended duration of oocyte banking (select all that apply)** ☐ Short term (<12 months) ☐ Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments ☐ Long term (≥12 months) banking for other reasons
Checkbox (MR)			**Intended duration of embryo banking (select all that apply)** ☐ Short term (<12 months) ☐ Delay of transfer to obtain genetic information ☐ Delay of transfer for other reasons ☐ Long term (≥12 months) banking for fertility preservation prior to gonadotoxic medical treatments ☐ Long term (≥12 months) banking for other reasons **[IF BANKING ONLY, SKIP TO #11 AFTER #9 IS COMPLETED]**
Checkbox (MR)	10	**Intended embryo source (select all that apply)** ☐ Patient embryos ☐ Donor embryos (donated from another patient's IVF cycle) ☐ FRESH embryos ☐ FROZEN embryos	
Checkbox (MR)	10A	**Intended oocyte source and state for FRESH embryos (select all that apply)** ☐ PATIENT oocytes ☐ PATIENT frozen oocytes ☐ DONOR fresh oocytes ☐ DONOR frozen oocytes **Intended oocyte source and state for FROZEN embryos (select all that apply)** ☐ PATIENT fresh oocytes ☐ PATIENT frozen oocytes ☐ DONOR fresh oocytes ☐ DONOR frozen oocytes ☐ DONOR Unknown (select only if oocyte source is unknown)	
Checkbox (MR + SR)	11	**Intended sperm source (select all that apply) [SKIP IF DONOR EMBRYO IS INTENDED SOURCE]** ☐ Partner ☐ Donor ☐ Patient, if male Or ☐ Unknown (select only if all sperm sources unknown)	
Drop-down	12	**Intended pregnancy carrier** ☐ Patient	

		☐ Gestational carrier ☐ None (oocyte or embryo banking cycle only)

ART PERFORMED		
		ART PERFORMED
Checkbox (MR + SR)	13	**Type of ART performed (select all that apply)** ☐ IVF: Transcervical ☐ GIFT: Gametes to tubes ☐ ZIFT: Zygotes to tubes or TET: tubal embryo transfer Or ☐ Oocyte or embryo banking **[SKIP TO #15 IF BANKING SELECTED]**
Checkbox (MR)	14	**Embryo source (select all that apply)** ☐ Patient embryos ☐ Donor embryos (donated from another patient's IVF cycle) ☐ FRESH embryos ☐ FROZEN embryos
Checkbox (MR)	14A	**Oocyte source and state for FRESH embryos (select all that apply)** ☐ PATIENT fresh oocytes ☐ PATIENT frozen oocytes ☐ DONOR fresh oocytes ☐ DONOR frozen oocytes **Oocyte source and state for FROZEN embryos (select all that apply)** ☐ PATIENT fresh oocytes ☐ PATIENT frozen oocytes ☐ DONOR fresh oocytes ☐ DONOR frozen oocytes ☐ DONOR Unknown (select only if oocyte source is unknown)

REASON FOR ART			
		REASON FOR ART	
Checkbox (MR)	15	**Reason for ART (select all that apply)** ☐ Male infertility	
		[SKIP IF MALE INFERTILITY NOT SELECTED]	☐ Medical condition ☐ Genetic or chromosomal abnormality (specify) _____ ☐ Abnormal sperm parameters ☐ Azoospermia, obstructive ☐ Azoospermia, non-obstructive ☐ Oligospermia, severe (<5 million/mL) ☐ Oligospermia, moderate (5-15 million/mL) ☐ Low motility (<40%) ☐ Low morphology (4%) ☐ Other male factor (not included above) (specify) _____
		☐ History of endometriosis	
		☐ Tubal ligation for contraception	
		☐ Current or prior hydrosalpinx	
		[SKIP IF HYDROSALPINX NOT SELECTED]	☐ Communicating ☐ Occluded ☐ Unknown
		☐ Other tubal disease (not current or prior hydrosalpinx)	
		☐ Ovulatory disorders	
		[SKIP IF OVULATORY DISORDER NOT SELECTED]	☐ Polycystic ovaries (PCO) ☐ Other ovulatory disorders
		☐ Diminished ovarian reserve	
		☐ Uterine factor	
		☐ Preimplantation genetic diagnosis (including aneuploidy screening) as primary reason for ART	
		☐ Oocyte or embryo banking as reason for ART	
		☐ Indication for use of gestational carrier	
		[SKIP IF GESTATIONAL CARRIER NOT INDICATED]	☐ Absence of uterus ☐ Significant uterine anomaly ☐ Medical contraindication to pregnancy ☐ Recurrent pregnancy loss ☐ Unknown
		☐ Recurrent pregnancy loss	
		☐ Other reasons related to infertility (specify) _____ _____ _____	

		☐ Other reasons not related to infertility (specify) _____ _____ _____
		☐ Unexplained infertility

FEMALE PATIENT HISTORY & PHYSICAL			
		FEMALE PATIENT HISTORY & PHYSICAL	
Text, checkbox (SR)	16	**[IF SEX OF PATIENT = MALE (FROM QUESTION #5) THEN SKIP #16-23]** **Height** |__| Feet and/or |__|__| Inches or |__|__|__|__| Centimeters Or ☐ Height unknown	
Text, checkbox (SR)		**Weight at the start of this cycle** |__|__|__|__| Pounds or |__|__|__|__| Kilograms Or ☐ Weight unknown	
Radio	18	Did the patient smoke during the 3 months before the cycle started? ☐ Yes ☐ No ☐ Unknown	
Radio	19	**Any prior pregnancies?** ◯Yes ◯ No	
Text	19A	**[SKIP IF NO PRIOR PREGNANCIES]** **If prior pregnancies reported and couple is not surgically sterile, enter months and/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 and/or years attempting pregnancy** **|__|__|__| months and/or |__|__| years**	
Text	19B	**[SKIP IF NO PRIOR PREGNANCIES]**	**Number of prior pregnancies |__|__|**
	19C		**Number of prior full term births (live and stillbirths) |__|__|**
			Number of prior preterm births (live and stillbirths) |__|__|
	19E		**Number of prior stillbirths |__|__|**
	19F		**Number of prior spontaneous abortions |__|__|**
	19G		**Number of prior ectopic pregnancies |__|__|**
	20	**Number of prior stimulations for fresh ART cycles |__|__|**	
	21	**Number of prior ART cycles started with the intent to transfer oocytes or embryos |__|__|**	
Radio	21A	**SKIP IF NO PRIOR ART CYCLES**	**Did any prior ART cycles result in a live birth? ◯Yes ◯ No**
Text, checkbox (SR)	22	**Maximum FSH level (MIU/mls) |__|__|__| . |__|__|** Or ☐ FSH level unknown	
Text, checkbox	23	**Most recent AMH level (ng/mL) |__|__|__| . |__|__|** Or	

(SR), date		☐ AMH level unknown **Date of most recent AMH level (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|**

SOURCES & CARRIERS		
		OOCYTE SOURCE PROFILE
Radio	24A	**[IF OOCYTE SOURCE = PATIENT AND DONOR, ANSWER THIS QUESTION]** **Youngest oocyte source** ☐ Patient [SKIP TO Q25] ☐ Donor [CONTINUE TO Q24B)
Date, drop-down, checkbox (SR)	24B	**Oocyte source date of birth (mm/dd/yyyy) [FIELD PRE-FILLED IF OOCYTE SOURCE=PATIENT]** |__|__| - |__|__| - |__|__|__|__| Or **Age at earliest time oocytes were retrieved ____**
Drop-down	25	**Oocyte source ethnicity** ○◯ NOT Hispanic or Latino ○◯ Hispanic or Latino ○◯ Refused ○◯ Unknown
Checkbox (MR)	26	**Oocyte source race (select all that apply)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native Or
Drop-down	26A	**Reason race not reported** ○◯ Refused ○◯ Unknown
Text, checkbox (SR)	O1	**Oocyte source height** |__| Feet and/or |__|__| Inches or |__|__|__|__| Centimeters Or ☐ Height unknown
Text, checkbox (SR)		**Oocyte source weight** |__|__|__|__| Pounds or |__|__|__|__| Kilograms Or ☐ Weight unknown
Radio	O3	Did the oocyte source smoke during the 3 months before the cycle started? ☐ Yes ☐ No ☐ Unknown

Radio	O3	**Any prior pregnancies?** ◯Yes ◯ No	
Text	O4	**[SKIP IF NO PRIOR PREGNANCIES]** **If prior pregnancies reported and couple is not surgically sterile, enter months and/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 and/or years attempting pregnancy |__|__|__| months and/or |__|__| years**	
Text		**[SKIP IF NO PRIOR PREGNANCIES]**	**Number of prior pregnancies |__|__|**
	O5A		**Number of prior full term births (live and stillbirths) |__|__|**
			Number of prior preterm births (live and stillbirths) |__|__|
	O5C		**Number of prior stillbirths |__|__|**
	O5D		**Number of prior spontaneous abortions |__|__|**
	O5E		**Number of prior ectopic pregnancies |__|__|**
	O5F	**Number of prior stimulations for ART cycles |__|__|**	
	O5G	**Number of prior ART cycles with the intent to transfer oocytes or embryos |__|__|**	
Radio	O6H	**SKIP IF NO PRIOR ART CYCLES started with intent to transfer**	**Did any prior ART cycles started with the intent to transfer oocytes or embryos result in a live birth? ◯Yes ◯ No**
Text, checkbox (SR)	O6	**Maximum FSH level (MIU/mls) |__|__|__| . |__|__|** Or ☐ FSH level unknown	
Text, checkbox (SR), date	O7	**Most recent AMH level (ng/mL) |__|__|__| . |__|__|** Or ☐ AMH level unknown **Date of most recent AMH level (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|**	
		PREGNANCY CARRIER PROFILE	
Drop-down	27	**Pregnancy carrier** ☐ Patient ☐ Gestational carrier ☐ None (oocyte or embryo banking cycle only)	
Date, drop-down, Checkbox (SR)	28	**[IF CARRIER=NONE THEN SKIP 28-31] or** **[IF CARRIER=PATIENT AND OOCYTE SOURCE=PATIENT THEN SKIP 28-31]** **Pregnancy carrier date of birth (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__| **Or** **Age at time of transfer ____**	
Drop-down	29	**Pregnancy carrier ethnicity**	

		○◯ NOT Hispanic or Latino ○◯ Hispanic or Latino ○◯ Refused ○◯ Unknown
Checkbox (MR)	30	**Pregnancy carrier race (select all that apply)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native Or
Drop-down	30A	**Reason race not reported** ○◯ Refused ○◯ Unknown
		SPERM SOURCE PROFILE
Checkbox (MR + SR)	31	**Specify sperm source (select all that apply)** ☐ Partner ☐ Donor ☐ Patient, if male Or ☐ Unknown (select only if all sperm sources unknown)
Date, checkbox (SR)	32	**Sperm source date of birth (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__| **[FIELD PRE-FILLED IF SPERM SOURCE=MALE PATIENT]** Or ☐ Sperm source DOB unknown
Drop-down	33	**Sperm source ethnicity** ○◯ NOT Hispanic or Latino ○◯ Hispanic or Latino ○◯ Refused ○◯ Unknown
Checkbox (MR)	34	**Sperm source race (select all that apply)** ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native Or
Drop-down	34A	**Reason race not reported** ○◯ Refused ○◯ Unknown

STIMULATION & MEDICATIONS			
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Radio	35	**Was there stimulation for follicular development?** ◯Yes ◯ No **[IF NO STIMULATION OR FROZEN CYCLE, SKIP #36-39]**	
		Was this a minimal stimulation cycle? ◯Yes ◯ No	
Radio	36	**Oral medication such as aromatase inhibitor or selective estrogen receptor modulator used** ◯Yes ◯ No	
Text	36A	**[SKIP IF NO ORAL MEDS]**	**Clomiphene dosage (Total mgs):** |__|__|__|__|__|__| . |__|__| **Letrozole dosage (Total mgs)** |__|__|__|__|__|__| . |__|__| **Other oral medication (specify)**_____ **Other oral medical dosage (specify)** |__|__|__|__|__|__| . |__|__|
Radio	37	**Medication containing FSH used** ◯**Yes** ◯ **No**	
Text	37A	**[SKIP IF NO FSH MEDS]**	**Short-acting FSH (Total IUs)** |__|__|__|__|__|__| . |__|__|
Text	37B		**Long-acting FSH (Total mgs)** |__|__|__|__|__|__| . |__|__|
Radio	38	**Medication with LH/HCG activity used** ◯**Yes** ◯ **No**	
Radio	39	**Primary GnRH protocol used** ◯ No GnRH protocol ◯ GnRH Agonist Suppression ◯ GnRH Agonist Flare ◯ GnRH Antagonist Suppression	
		CANCELLATION	
Radio	40	**[IF OOCYTE/EMBRYO SOURCE = FROZEN THEN SKIP 40-45]** **Cycle canceled prior to retrieval?** ◯Yes ◯ No	
Date	40A	**[SKIP IF CYCLE NOT CANCELLED]**	**Date cycle canceled (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__|
Radio, text	40B		**Primary reason cycle was canceled** ☐ **Low ovarian response** ☐ **High ovarian response** ☐ **Inadequate endometrial response** ☐ **Concurrent illness** ☐ **Withdrawal only for personal reasons** ☐ **Other (specify)** _____

RETRIEVAL			
		FRESH OOCYTE RETRIEVAL	
Date	41	**Date retrieval performed (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__|	
Text	42	**Number of patient oocytes retrieved** |__|__|	
Text	43	**Number of donor oocytes retrieved** |__|__|	
Checkbox (MR)	44	**Use of retrieved oocytes (select all that apply)** ☐ Used for this cycle ☐ Oocytes frozen for future use ☐ Oocytes shared with other patients ☐ Embryos frozen for future use	
		Were there any oocyte retrieval performed from other clinics? ◯Yes ◯ No	
Text	44A	**[SKIP IF NO OOCYTES FROZEN]**	**Number of fresh oocytes frozen for future use** |__|__|
		COMPLICATIONS OF OVARIAN STIMULATION OR OOCYTE RETRIEVAL	
Radio	45	**Were there any complications of ovarian stimulation or oocyte retrieval?** ◯Yes ◯ No	
Checkbox (MR), text	45A	**[SKIP IF NO COMPLICATION]**	**Complications (select all that apply)** ☐ Infection ☐ Hemorrhage requiring transfusion ☐ Ovarian hyperstimulation requiring intervention or hospitalization ☐ Medication side effect ☐ Anesthetic complication ☐ Thrombosis ☐ Death of patient ☐ Other (specify) _____
Radio	45B	**[SKIP IF NO COMPLICATION]**	**Did the complication(s) require hospitalization?** ◯Yes ◯ No
		SPERM RETRIEVAL	
Radio	46	**Sperm status** ☐ Fresh ☐ Thawed ☐ Mix of fresh and thawed	
Radio	47	**Sperm source utilized** ○◯ Ejaculated ○◯ Epididymal ○◯ Testis ○◯ Electroejaculation ○◯ Retrograde urine ○◯ Donor ○◯ Unknown	

MANIPULATION			
		MANIPULATION	
Radio	48	**Intracytoplasmic sperm injection (ICSI) performed on oocytes?** ○◯ All oocytes ○◯ Some oocytes ○◯ No oocytes ○◯ Unknown	
Checkbox (MR), text	48A	**SKIP IF NO ICSI**	**Indication for ICSI (select all that apply)** ○◯ Prior failed fertilization ○◯ Poor fertilization ○◯ PGD or PGS ○◯ Abnormal semen parameters on day of fertilization ○◯ Low oocyte yield ○◯ Laboratory routine ○◯ Frozen oocyte ○◯ Rescue ICSI ○◯ Other (specify) _____
Radio	49	**In vitro maturation (IVM) performed on oocytes?** ○◯ All oocytes ○◯ Some oocytes ○◯ No oocytes ○◯ Unknown	
Radio	50	**Pre-implantation genetic diagnosis (PGD) or screening (PGS) performed on embryos?** ○◯ Yes ○◯ No ○◯ Unknown	
Text	50A	**SKIP IF PGD/PGS NOT PERFORMED OR UNKNOWN**	**Total number of 2PN** |__|__|
Checkbox (MR)	50B		**Reason for PGD or PGS (select all that apply)** ☐ Either genetic parent is a known carrier of a gene mutation or a chromosomal abnormality ☐ Aneuploidy screening of the embryos ☐ Elective gender determination ☐ Other screening of the embryos
Checkbox (MR + SR)	50C		**Technique used for PGD or PGS (select all that apply)** ☐ Polar Body Biopsy ☐ Blastomere Biopsy ☐ Blastocyst Biopsy Or ☐ Unknown
Radio	51	**Assisted hatching performed on embryos?** ○◯ All embryos ○◯ Some embryos ○◯ No embryos ○◯ Unknown	

Radio	52	**Was this a research cycle?** ○◯ Yes ○◯ No	
Checkbox (MR), text	52A	**[SKIP IF NOT RESEARCH CYCLE]**	**Study type (select all that apply)** ☐ Device study ☐ Protocol study ☐ Pharmaceutical study ☐ Laboratory technique ☐ Other research (specify) _____
Text	52B		Approval code_____

TRANSFER			
		TRANSFER ATTEMPT	
Radio	53	**Was a transfer attempted?** ◯Yes ◯ No	
Radio, text	53A	**[SKIP IF TRANSFER ATTEMPTED]**	**Primary reason no transfer was attempted** ☐ Low ovarian response ☐ High ovarian response ☐ Failure to survive oocyte thaw ☐ Inadequate endometrial response ☐ Concurrent illness ☐ Withdrawal only for personal reasons ☐ Unable to obtain sperm specimen ☐ Insufficient embryos ☐ Other (specify) _____
		[IF TRANSFER NOT ATTEMPTED, STOP HERE]	
		GENERAL TRANSFER DETAILS	
Date	54	**Date transfer performed (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|**	
Text	55	**Endometrial thickness at trigger |__|__|mm**	
		FRESH EMBRYO TRANSFER DETAILS	
Text	55N	**Number of fresh embryos available on day of transfer |__|__|**	
Text	56	**[IF NO FRESH EMBRYOS TRANSFERRED, SKIP #57-58]** **Number of fresh embryos transferred to uterus |__|__|**	
Radio	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?** ◯Yes ◯ No	
Drop-down	58A-X	**Quality of embryo #1–X** ☐ Good ☐ Fair ☐ Poor ☐ Unknown	
Drop-down, date, checkbox (SR)	58B		**Date of oocyte retrieval for embryo #1-X (mm/dd/yyyy) [DROPDOWN]** **Or** |__|__| - |__|__| - |__|__|__|__|
	58C	**Was the oocyte used to create the fresh embryo #1-X retrieved in a different clinic?** ○◯Yes ◯ No **If Yes, state [dropdown], city [dropdown], name of clinic [dropdown]** **or _____[text], if not found in the dropdown menu**	
Text	59	**Number of fresh embryos cryopreserved |__|__| [STOP HERE FOR EMBRYO BANKING ONLY CYCLE]**	
		FROZEN EMBRYO TRANSFER DETAILS	
Text	60	**Number of frozen or thawed embryos available on day of transfer |__|__|**	
Text	61	**Number of thawed embryos transferred to uterus |__|__| [IF NO THAWED EMBRYOS TRANSFERRED, SKIP #62]**	

Radio	62	**[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?** ○◯Yes ◯ No
Drop-down	62A-X	**Quality of embryo #1–X** ☐ Good ☐ Fair ☐ Poor ☐ Unknown
Drop-down, date	62B	**Date of oocyte retrieval for embryo #1-X (mm/dd/yyyy) [DROPDOWN]** **Or** |__|__| - |__|__| - |__|__|__|__|
	62C	**Was the oocyte used to create the thawed embryo #1-X retrieved in a different clinic?** ○◯Yes ◯ No **If Yes, state [dropdown], city [dropdown], name of clinic [dropdown]** **or _____[text], if not found in the dropdown menu**
Text	63	**Number of thawed embryos cryopreserved (re-frozen) |__|__|**
		GIFT/ZIFT/TET TRANSFER DETAILS
Text	64	**[SKIP IF IVF CYCLE]** **Number of oocytes or embryos transferred to the fallopian tube |__|__|**

OUTCOMES			
		OUTCOME OF TRANSFER	
Radio	65	**Outcome of treatment cycle** ☐ Not pregnant ☐ Biochemical only ☐ Clinical intrauterine gestation ☐ Ectopic ☐ Heterotopic ☐ Unknown **[IF NOT PREGNANT, BIOCHEMICAL ONLY, ECTOPIC, OR HETEROTOPIC, STOP HERE]**	
Text, checkbox (SR)	66		**Maximum number of fetal hearts on ultrasound performed before 7 weeks or prior to reduction** |__|__| ☐ **No ultrasound performed before 7 weeks gestation or prior to reduction**
Date	66A	**[SKIP IF NO U/S]**	**Ultrasound date with maximum number of fetal hearts observed before 7 weeks or prior to reduction (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__|
Radio	66B	**[SKIP IF NO U/S]**	**Any monochorionic twins or multiples?** ◯**Yes** ◯ **No** ◯**Unknown**
		OUTCOME OF PREGNANCY	
Radio	67	**Outcome of pregnancy** ☐ Live birth ☐ Spontaneous abortion ☐ Stillbirth ☐ Induced abortion ☐ Maternal death prior to birth ☐ Outcome unknown	
Date	68	**Date of pregnancy outcome (mm/dd/yyyy)** |__|__| - |__|__| - |__|__|__|__|	
Checkbox (MR)	69	**Source of information confirming pregnancy outcome (select all that apply)** ☐ Verbal confirmation from patient ☐ Written confirmation from patient ☐ Verbal confirmation from physician or hospital ☐ Written confirmation from physician or hospital	
		[If spontaneous abortion, induced abortion, maternal death prior to birth, or outcome unknown, STOP here]	
Text	70	**Number of infants born** |__|__|	
Radio	69N	**Method of delivery** ◯ Vaginal ◯ Cesarean ◯ Unknown	

BIRTHS		
		BIRTH INFORMATION
Radio	71A-X	**Infant #1-X: Birth status** ☐ Live born ☐ Stillborn ☐ Unknown
Radio	72A-X	**Infant #1-X: Gender** ☐ Male ☐ Female ☐ Unknown
Drop-down, text, checkbox (SR)	73A-X	**Infant #1-X: Weight** **|__|__| Pounds And |__|__| Ounces Or |__|__|__|__| Grams** **Or** ☐ **Weight unknown**
Checkbox (MR + SR)	74A-X	**Infant #1-X: Birth defects (select all that apply)** ☐ Cleft lip/palate ☐ Genetic defect/chromosomal abnormality ☐ Neural tube defect ☐ Cardiac defect ☐ Limb defect ☐ Other (specify) Or ☐ Birth defects unknown Or ☐ None
		[END]