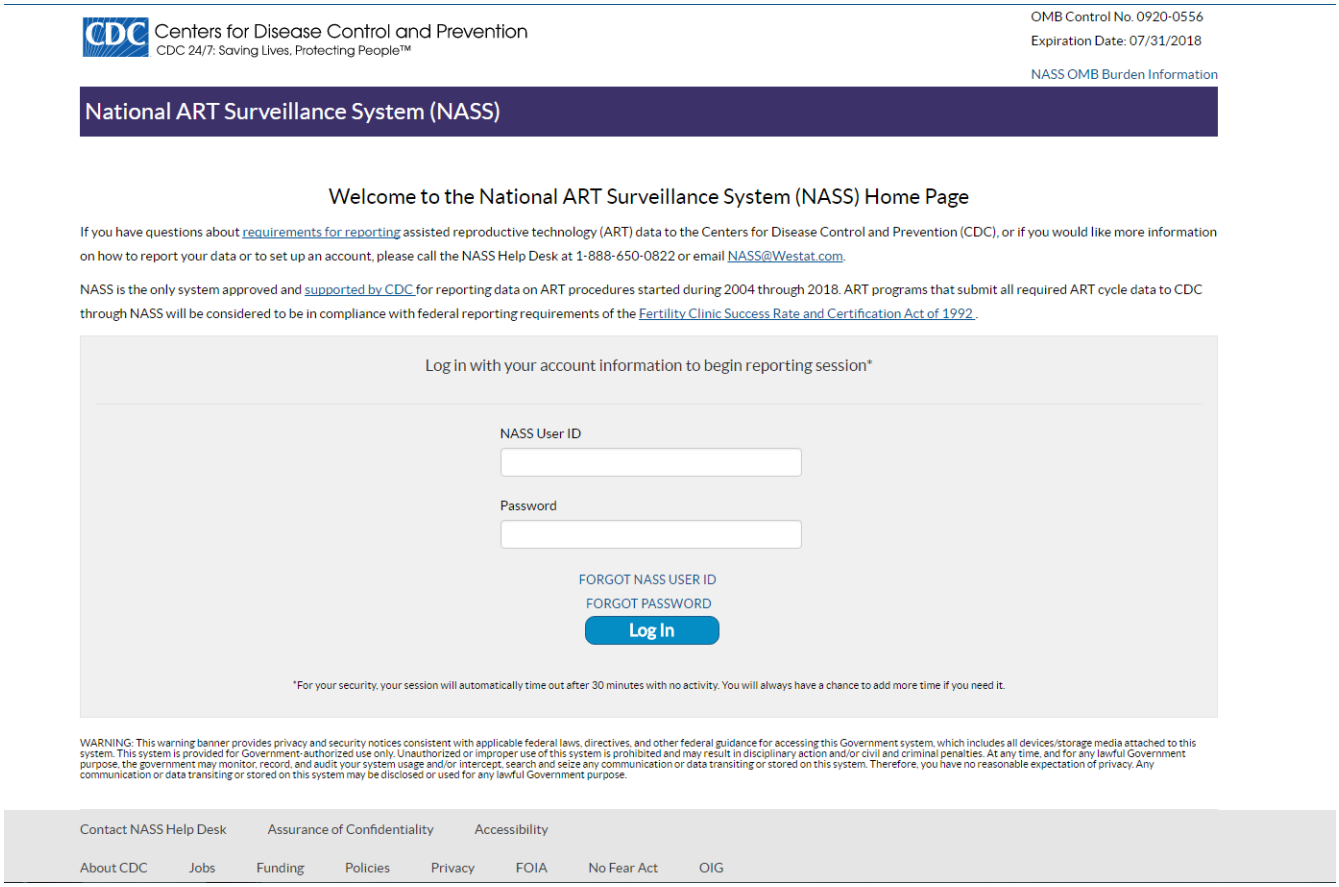
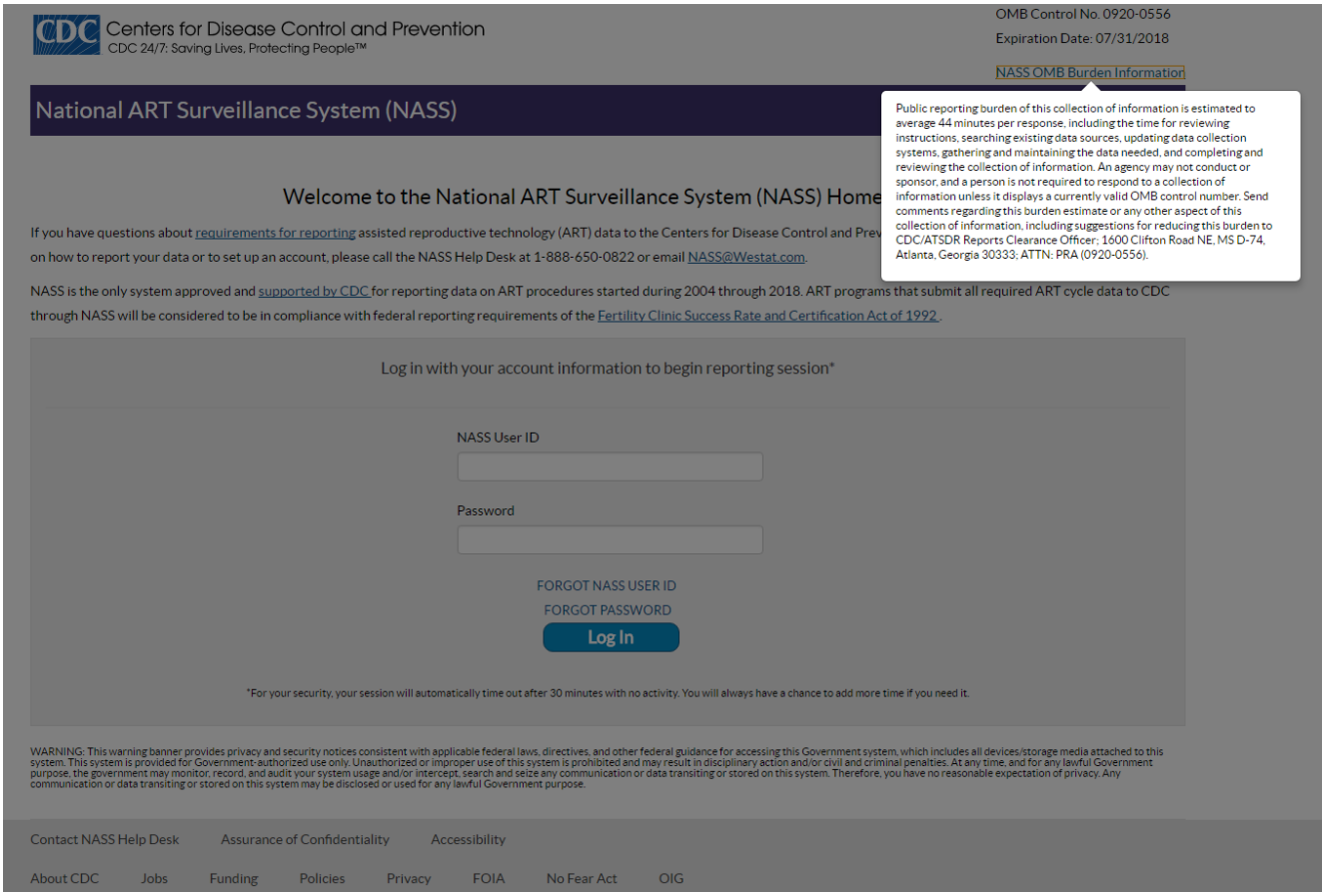
NASS 2.0 Log-in Web Page





INITIAL REPORTING PAGE

PATIENT PROFILE SECTION

NASS patient ID |__|__|__|__| - |__|__|__|__| - |__|__|

Patient Optional Identifiers

Optional identifier 1 |__|__|__|__|__|__|__|

Optional identifier 2 |__|__|__|__|__|__|__|

Patient date of birth (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Sex of patient

◯ Female

◯ Male

Cycle start date|__|__| - |__|__| - |__|__|__|__|

RESIDENCY SECTION

At the start of cycle, is patient residency primarily in U.S.?

◯ Yes

◯ No

◯ Refused

U.S. city of primary residence |_____|

U.S. state of primary residence |_____|

U.S. zip code of primary residence |_____|

Country of primary residence |_____|

INTENT SECTION

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

[IF BANKING] Banking type (select all that apply)

☐ Embryo banking

☐ Autologous oocyte banking

☐ Donor oocyte banking

[IF EMBRYO BANKING] 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 AUTOLOGOUS AND/OR DONOR OOCYTE BANKING] 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

[IF IVF/GIFT/ZIFT] Intended embryo source (select all that apply)

- ☐ Patient embryos

  Intended oocyte source and state for FRESH patient embryos (select all that apply)

  - ☐ PATIENT fresh oocytes
  - ☐ DONOR fresh oocytes
  - ☐ PATIENT frozen oocytes
  - ☐ DONOR frozen oocytes

  Intended oocyte source and state for FROZEN patient embryos (select all that apply)

  - ☐ PATIENT fresh oocytes
  - ☐ DONOR fresh oocytes
  - ☐ PATIENT frozen oocytes
  - ☐ DONOR frozen oocytes
  - ☐ DONOR unknown (select only if oocyte source is unknown)

- ☐ Donor embryos (DONATED FROM ANOTHER PATIENT'S IVF CYCLE)
  - ☐ FRESH donor embryos
  - ☐ FROZEN donor embryos

Intended sperm source (select all that apply)

- ☐ Partner
- ☐ Donor
- ☐ Patient, if male

(OR)

- ☐ Unknown (select only if all sperm sources unknown)

Intended pregnancy carrier

- ◯ Patient
- ◯ Gestational carrier
- ◯ None (oocyte or embryo banking cycle only)

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

[IF IVF/GIFT/ZIFT] Embryo source (select all that apply)

- ☐ Patient embryos

  Oocyte source and state for FRESH patient embryos (select all that apply)

  - ☐ PATIENT fresh oocytes
  - ☐ DONOR fresh oocytes
  - ☐ PATIENT frozen oocytes
  - ☐ DONOR frozen oocytes

  Oocyte source and state for FROZEN patient embryos (select all that apply)

  - ☐ PATIENT fresh oocytes
  - ☐ DONOR fresh oocytes
  - ☐ PATIENT frozen oocytes
  - ☐ DONOR frozen oocytes
  - ☐ DONOR unknown (select only if oocyte source is unknown)

- ☐ Donor embryos (DONATED FROM ANOTHER PATIENT'S IVF CYCLE)
  - ☐ FRESH donor embryos
  - ☐ FROZEN donor embryos

Reason for ART (select all that apply)

- ☐ Male infertility
  - ☐ Medical condition
  - ☐ Genetic or chromosomal abnormality (specify) |_____|
  - ☐ Abnormal sperm parameters
    - ☐ Azoospermia, obstructive
    - ☐ Azoospermia, non-obstructive
    - ☐ Oligozoospermia, severe (<5 million/mL)
    - ☐ Oligozoospermia, moderate (5-15 million/mL)
    - ☐ Low motility (<40%)
    - ☐ Low morphology
  - ☐ Other male factor (specify) |_____|
- ☐ History of endometriosis
- ☐ Tubal ligation for contraception
- ☐ Current or prior hydrosalpinx
  - ☐ Communicating
  - ☐ Occluded
  - ☐ Unknown
- ☐ Other tubal disease (not current or prior hydrosalpinx)
- ☐ Ovulatory disorders
  - ☐ 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
  - ☐ 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 <u>not</u> related to infertility (specify) |_____|
- ☐ Unexplained infertility

Height

|__| Feet (**AND/OR**) |__|__| Inches (**OR**) |__|__|__|__| Centimeters

(OR)

☐ Height unknown

Weight at the start of this cycle

|__|__|__|__| Pounds **(OR)** |__|__|__|__| Kilograms

(OR)

☐ Weight unknown

Did the patient smoke during the 3 months before the cycle started?

◯ Yes
◯ No
◯ Unknown

Any prior pregnancies?

◯ Yes

If yes, and couple is not surgically sterile, enter months and/or years attempting pregnancy since last clinical pregnancy

|__|__|__| months AND/OR |__|__| years

Number of prior pregnancies |__|__|

Number of prior full term births (live and stillbirths) |__|__|

Number of prior preterm births (live and stillbirths) |__|__|

Number of prior stillbirths |__|__|

Number of prior spontaneous abortions |__|__|

Number of prior ectopic pregnancies |__|__|

◯ No

If no, and couple is not surgically sterile, enter months and/or years attempting pregnancy

|__|__|__| months AND/OR |__|__| years

Number of prior stimulations for ART cycles |__|__|

Number of prior frozen ART cycles |__|__|

[IF PRIOR ART] Did any prior ART cycles result in a live birth?

◯Yes
◯No

Maximum FSH level (MIU/mls) |__|__|__| . |__|__|

(OR)

☐ FSH level unknown

Date of most recent AMH level (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Most recent AMH level (ng/mL) |__|__|__| . |__|__|

(OR)

☐ AMH level unknown

OOCYTE SOURCE PROFILE SECTION

Youngest oocyte source

- ◯ Patient
- ◯ Donor

Oocyte source date of birth (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

(OR)

Age at earliest time oocytes were retrieved |__|__|

Oocyte source ethnicity

- ◯ Not Hispanic or Latino
- ◯ Hispanic or Latino
- ◯ Refused
- ◯ Unknown

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)

Reason race not reported

- ◯ Refused
- ◯ Unknown

PREGNANCY CARRIER PROFILE SECTION

Pregnancy carrier

- ◯ Patient
- ◯ Gestational carrier
- ◯ None (oocyte or embryo banking cycle only)

Pregnancy carrier date of birth (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

(OR)

Age at time of transfer |__|__|

Pregnancy carrier ethnicity

- ◯ Not Hispanic or Latino
- ◯ Hispanic or Latino
- ◯ Refused
- ◯ Unknown

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)

Reason race not reported

◯ Refused

◯ Unknown

SPERM SOURCE PROFILE SECTION

Specify sperm source (select all that apply)

☐ Partner

☐ Donor

☐ Patient, if male

(OR)

☐ Unknown (select only if all sperm sources unknown)

Sperm source date of birth (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

(OR)

☐ Sperm source date of birth unknown

Sperm source ethnicity

◯ Not Hispanic or Latino

◯ Hispanic or Latino

◯ Refused

◯ Unknown

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)

Reason race not reported

◯ Refused

◯ Unknown

STIMULATION & MEDICATIONS SECTION

Was there stimulation for follicular development?

- ◯ Yes
- ◯ No

Was this a minimal stimulation cycle?

- ◯ Yes
- ◯ No

Oral medication such as aromatase inhibitor or selective estrogen receptor modulator used

- ◯ Yes
  - **Clomiphene dosage (Total mgs)** |__|__|__|__|__| . |__|__|
  - **Letrozole dosage (Total mgs)** |__|__|__|__|__| . |__|__|
  - **Other oral medication (specify)** |_____|
  - **Other oral medical dosage (specify)** |__|__|__|__|__| . |__|__|
- ◯ No

Medication containing FSH used

- ◯ Yes
  - **Short-acting FSH (Total IUs)** |__|__|__|__|__| . |__|__|
  - **Long-acting FSH (Total mgs)** |__|__|__|__|__| . |__|__|
- ◯ No

Medication with LH/HCG activity used

- ◯ Yes
- ◯ No

Primary GnRH protocol used

- ◯ No GnRH protocol
- ◯ GnRH Agonist Suppression
- ◯ GnRH Agonist Flare
- ◯ GnRH Antagonist Suppression

CANCELLATION SECTION

Cycle canceled prior to retrieval?

- ◯ Yes
- ◯ No

Date cycle canceled (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Primary reason cycle was canceled

- ◯ Low ovarian response
- ◯ High ovarian response
- ◯ Inadequate endometrial response
- ◯ Concurrent illness
- ◯ Withdrawal only for personal reasons
- ◯ Other (specify) |_____|

RETRIEVAL PAGE

FRESH OOCYTE RETRIEVAL SECTION

Date retrieval performed (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Number of patient oocytes retrieved |__|__|

Number of donor oocytes retrieved |__|__|

Use of retrieved oocytes (select all that apply)

☐ Used for this cycle

☐ Oocytes frozen for future use

Number of fresh oocytes frozen for future use |__|__|

☐ Oocytes shared with other patients

☐ Embryos frozen for future use

COMPLICATIONS OF OVARIAN STIMULATION OR OOCYTE RETRIEVAL SECTION

Were there any complications of ovarian stimulation or oocyte retrieval?

◯ Yes

◯ No

[IF YES] 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) |_____|

Did the complication(s) require hospitalization?

◯ Yes

◯ No

SPERM RETRIEVAL SECTION

Sperm status

◯ Fresh

◯ Thawed

◯ Mix of fresh and thawed

◯ Unknown

Sperm source utilized

◯ Ejaculated

◯ Epididymal

◯ Testis

◯ Electroejaculation

◯ Retrograde urine

◯ Donor

◯ Unknown

Intracytoplasmic sperm injection (ICSI) performed on oocytes?

- ◯ All oocytes
- ◯ Some oocytes
- ◯ No oocytes
- ◯ Unknown

[IF 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) |_____|

In vitro maturation (IVM) performed on oocytes?

- ◯ All oocytes
- ◯ Some oocytes
- ◯ No oocytes
- ◯ Unknown

Pre-implantation genetic diagnosis (PGD) or screening (PGS) performed on embryos?

- ◯ Yes
- ◯ No
- ◯ Unknown

[IF PGD/PGS]

Total number of 2PN |__|__|

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

Technique used for PGD or PGS (select all that apply)

- ☐ Polar Body Biopsy
- ☐ Blastomere Biopsy
- ☐ Blastocyst Biopsy

(OR)

- ☐ Unknown

Assisted hatching performed on embryos?

- ◯ All embryos
- ◯ Some embryos
- ◯ No embryos
- ◯ Unknown

Was this a research cycle?

- ◯ Yes
- ◯ No

[IF YES] Study type (select all that apply)

- ☐ Device study
- ☐ Protocol study
- ☐ Pharmaceutical study
- ☐ Laboratory technique
- ☐ Other research (specify) |_____|

Approval code |_____|

TRANSFER ATTEMPT SECTION

Was a transfer attempted?

◯ Yes

◯ No

[IF NO] 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) |_____|

GENERAL TRANSFER DETAILS SECTION

Date transfer performed (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Endometrial thickness at trigger |__|__|mm

FRESH EMBRYO TRANSFER DETAILS SECTION

Number of fresh embryos transferred to uterus |__|__|

If only <u>one</u> fresh embryo was transferred to the uterus, was this an <u>elective</u> single embryo transfer?

◯ Yes

◯ No

Quality of embryo #1

◯ Good

◯ Fair

◯ Poor

◯ Unknown

Date of oocyte retrieval for embryo #1 (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Quality of embryo #2

◯ Good

◯ Fair

◯ Poor

◯ Unknown

Date of oocyte retrieval for embryo #2 (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Number of fresh embryos cryopreserved |__|__|

FROZEN EMBRYO TRANSFER DETAILS

Number of thawed embryos transferred to uterus |__|__|

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

- ◯ Yes
- ◯ No

Quality of embryo #1

- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Unknown

Date of oocyte retrieval for embryo #1 (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Quality of embryo #2

- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Unknown

Date of oocyte retrieval for embryo #2 (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

Number of thawed embryos cryopreserved (re-frozen) |__|__|

GIFT/ZIFT/TET TRANSFER DETAILS SECTION

Number of oocytes or embryos transferred to the fallopian tube |__|__|

OUTCOME OF TRANSFER SECTION

Outcome of treatment cycle

- ◯ Not pregnant
- ◯ Biochemical
- ◯ Clinical intrauterine gestation
- ◯ Ectopic
- ◯ Heterotopic
- ◯ Unknown

Maximum number of fetal hearts on ultrasound performed before 7 weeks or prior to reduction |__|__|

(OR)

☐ No ultrasound performed before 7 weeks gestation or prior to reduction

[IF ULTRASOUND]

Ultrasound date with maximum number of fetal hearts observed before 7 weeks or prior to reduction (mm/dd/yyyy)

|__|__| - |__|__| - |__|__|__|__|

Any monochorionic twins or multiples?

- ◯ Yes
- ◯ No
- ◯ Unknown

OUTCOME OF PREGNANCY SECTION

Outcome of pregnancy

- ◯ Live birth
- ◯ Spontaneous abortion
- ◯ Stillbirth
- ◯ Induced abortion
- ◯ Maternal death prior to birth
- ◯ Outcome unknown

Date of pregnancy outcome (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

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

Number of infants born |__|__|

Method of delivery

- ◯ Vaginal
- ◯ Cesarean
- ◯ Unknown

BIRTH INFORMATION INFANT #1

Infant #1: Birth status

◯ Live born
◯ Stillborn
◯ Unknown

Infant #1: Gender

◯ Male
◯ Female
◯ Unknown

Infant #1: Weight

|__|__| Pounds **AND** |__|__| Ounces

(OR)

|__|__|__|__| Grams

(OR)

☐ Weight unknown

Infant #1: 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

BIRTH INFORMATION INFANT #2

Infant #2: Birth status

◯ Live born

◯ Stillborn

◯ Unknown

Infant #2: Gender

◯ Male

◯ Female

◯ Unknown

Infant #2: Weight

|__|__| Pounds **AND** |__|__| Ounces

(OR)

|__|__|__|__| Grams

(OR)

☐ Weight unknown

Infant #2: 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

BIRTH INFORMATION INFANT #3

Infant #3: Birth status

◯ Live born

◯ Stillborn

◯ Unknown

Infant #3: Gender

◯ Male

◯ Female

◯ Unknown

Infant #3: Weight

|__|__| Pounds **AND** |__|__| Ounces

(OR)

|__|__|__|__| Grams

(OR)

☐ Weight unknown

Infant #3: 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