

National ART Surveillance System (NASS)

Welcome to the National ART Surveillance System (NASS) Home Page

If you have questions about [requirements for reporting](#) assisted reproductive technology (ART) data to the Centers for Disease Control and Prevention (CDC), or if you would like more information on how to report your data or to set up an account, please call the NASS Help Desk at 1-888-650-0822 or email NASS@Westat.com.

NASS is the only system approved and [supported by CDC](#) for reporting data on ART procedures started during 2004 through 2018. ART programs that submit all required ART cycle data to CDC through NASS will be considered to be in compliance with federal reporting requirements of the [Fertility Clinic Success Rate and Certification Act of 1992](#).

Log in with your account information to begin reporting session*

NASS User ID

Password

[FORGOT NASS USER ID](#)
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*For your security, your session will automatically time out after 30 minutes with no activity. You will always have a chance to add more time if you need it.

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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 (\geq 12 months) banking for fertility preservation prior to gonadotoxic medical treatments
- Long term (\geq 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 PAGE

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 not 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) |_____|

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 one fresh 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 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