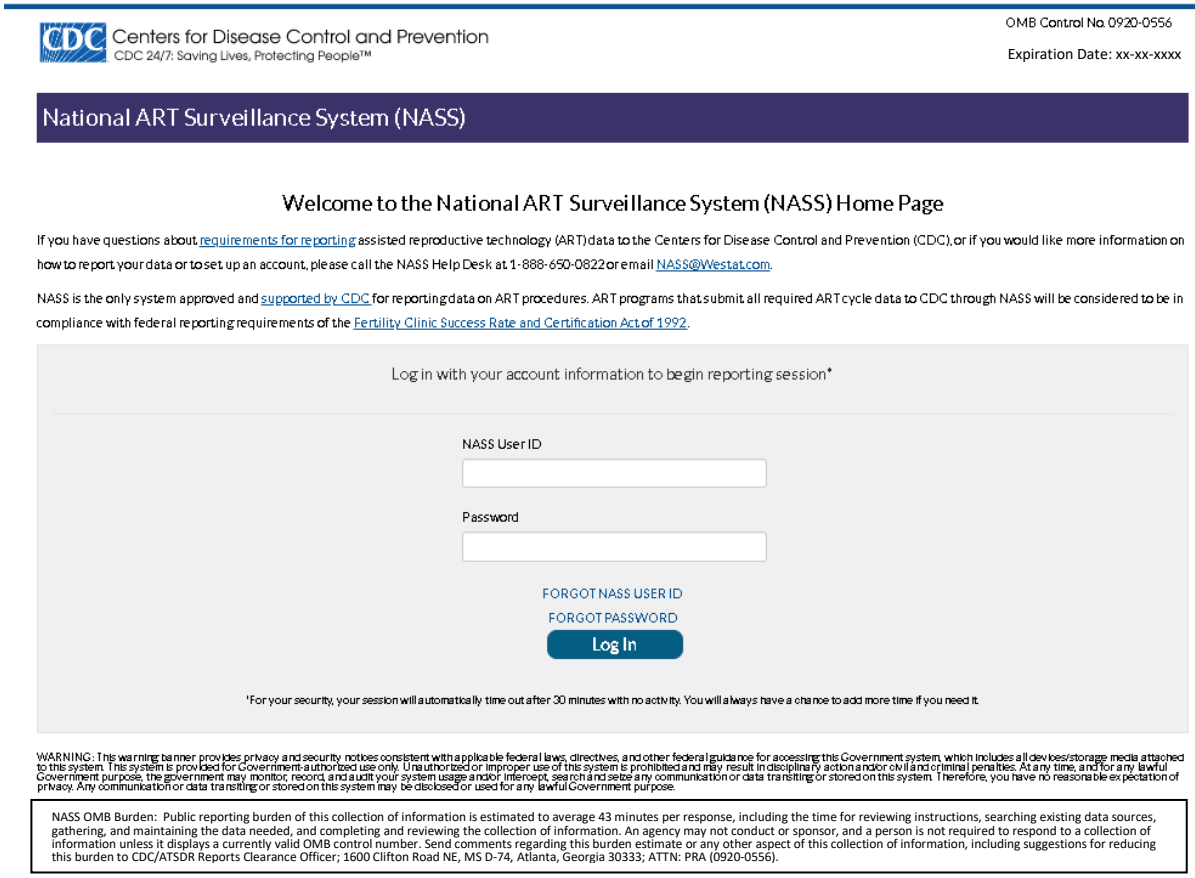
NASS 2.0 Log-in Web Page



Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

OMB Control No. 0920-0556
Expiration Date: xx-xx-xxxx

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. 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
FORGOT PASSWORD
Log In

*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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NASS OMB Burden: Public reporting burden of this collection of information is estimated to average 43 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).

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

Patient ethnicity

◯ NOT Hispanic or Latino

◯ Hispanic or Latino

◯ Refused

◯ Unknown

Patient 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

Cycle start date (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__|

RESIDENCY SECTION

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

◯ Yes

◯ No

◯ Refused

U.S. state of primary residence |_____|

U.S. city of primary residence |_____|

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

Country of primary residence |_____|

(continued next page)

INITIAL REPORTING PAGE (continued)

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 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 donated embryos
  - ☐ FROZEN donated embryos

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

- ☐ Embryo banking
- ☐ Autologous oocyte banking
- ☐ Donor oocyte banking

[IF EMBRYO BANKING] Intended source for embryo banking (select all that apply)

- ☐ Embryo banking from autologous oocytes
- ☐ Embryo banking from donor oocytes

[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

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INITIAL REPORTING PAGE (continued)

[IF AUTOLOGOUS 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

Intended sperm source (select all that apply)

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

(OR)

- ☐ Unknown (select only if <u>all</u> sperm sources unknown)

Intended pregnancy carrier

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

ART PERFORMED PAGE

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 donated embryos

☐ FROZEN donated 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 (4%)
  - ☐ Other male factor (specify) |_____|
- ☐ History of endometriosis
- ☐ Tubal ligation for contraception
- ☐ Current or prior hydrosalpinx
  - ☐ Communicating
  - ☐ Occluded
  - ☐ Unknown (current or prior hydrosalpinx)
- ☐ Other tubal disease (not current or prior hydrosalpinx)
- ☐ Ovulatory disorders
  - ☐ Polycystic ovaries (PCO)
  - ☐ Other ovulatory disorders
- ☐ Diminished ovarian reserve
- ☐ Uterine factor
- ☐ Preimplantation genetic testing (including aneuploidy screening) as 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 (as indication for use of gestational carrier)
  - ☐ Unknown (indication for use of gestational carrier)
- ☐ Recurrent pregnancy loss
- ☐ Other reasons related to infertility (specify) |_____|
- ☐ Other reasons not related to infertility (specify) |_____|
- ☐ Unexplained infertility

FEMALE PATIENT HISTORY & PHYSICAL PAGE

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 prior pregnancies reported and couple is not surgically sterile, enter months 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 stillborn infants |__|__|

Number of prior spontaneous abortions |__|__|

Number of prior ectopic pregnancies |__|__|

◯ No

If no prior pregnancies reported and couple is not surgically sterile, enter months or years attempting pregnancy

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

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

Number of prior ART cycles started with the intent to transfer oocytes or embryos |__|__|

[IF PRIOR ART AND PRIOR PREGNANCY] Did any of the 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

SOURCES & CARRIERS PAGE

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

(continued next page)

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 PAGE

STIMULATION & MEDICATIONS SECTION

Was there stimulation for follicular development?

◯ Yes

◯ No

[If YES, STIMULATION]

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

◯

(continued next page)

STIMULATION & MEDICATIONS PAGE (continued)

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

○
○

MANIPULATION PAGE

Intracytoplasmic sperm injection (ICSI) performed on oocytes?

○ All oocytes
Some oocytes
No oocytes
○ Unknown

[IF ALL OR SOME ICSI] Indication for ICSI (select all that apply)

☐ Prior failed fertilization
☐ Poor fertilization
☐ PGT
☐ 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 testing (PGT) performed on embryos?

○ Yes
○ No
○ Unknown

[IF YES]

Total number of 2PN |__|__|

Reason for PGT (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 PGT (select all that apply)

Polar Body Biopsy

○

○

☐ Blastomere Biopsy

☐ Blastocyst Biopsy

☐ **(OR)**

Unknown

☐

(continued next page)

MANIPULATION PAGE (continued)

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 PAGE

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) |__|__| - |__|__| - |__|__|__|__|

Most recent endometrial thickness |__|__|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

[FOR <u>EACH</u> FRESH EMBRYO TRANSFERRED TO UTERUS]

Quality of embryo

◯ Good
◯ Fair
◯ Poor
◯ Unknown

Date of oocyte retrieval (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__| Was

the oocyte used to create this embryo retrieved from a different clinic?

◯ Yes
◯ No

If yes, clinic name |_____|

Clinic city |_____|

○

○

Clinic state |_____|

Number of fresh embryos cryopreserved |__|__|

(continued next page)

TRANSFER PAGE (continued)

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

[FOR EACH THAWED EMBRYO TRANSFERRED TO UTERUS]

Quality of embryo

◯ Good

◯ Fair

◯ Poor

◯ Unknown

Date of oocyte retrieval (mm/dd/yyyy) |__|__| - |__|__| - |__|__|__|__| **Was the oocyte used to create this embryo retrieved from a different clinic?**

◯ Yes

◯ No

If yes, clinic name |_____|

Clinic city |_____|

Clinic state |_____|

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

GIFT/ZIFT/TET TRANSFER DETAILS SECTION

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

OUTCOMES PAGE

OUTCOME OF TRANSFER SECTION

Outcome of treatment cycle

◯ Not pregnant

◯ Biochemical

◯ Clinical intrauterine gestation

◯ Ectopic

◯ Heterotopic

◯ Unknown

[IF CIU OR HETEROTOPIC]

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 PAGE

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

(this page may be copied for additional infant births)