**National ART Surveillance System**

**NASS 2.0**

**(Proposed for 2016)**

**DRAFT**

INITIAL REPORTING: PATIENT PROFILE (prosPEctive)

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| **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:** ⃝ Male ⃝ Female |
|  6 | **Cycle Start Date**|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_| |
|  | **RESIDENCY**  |
| 7 | **At the start of the cycle, is patient residency primarily in U.S.?**⃝Yes⃝ No⃝ Refused  |
|  7A | **U.S. state of primary residence:** **City of primary residence****U.S. zip code at primary residence** |\_\_|\_\_|\_\_|\_\_|\_\_|**OR****Country of primary residence:**  |
|  | **INTENT**  |
|  8 | **Intended type of ART? Select all that apply:**[ ]  IVF: Transcervical[ ]  GIFT: Gametes to tubes [ ]  ZIFT: Zygotes to tubes or TET: tubal embryo transfer[ ]  Oocyte or embryo banking |
|  9 | **[SKIP IF NOT A BANKING ONLY CYCLE]** | **If cycle is for banking only, specify banking type (select all that apply):**[ ]  Embryo banking [ ]  Autologous oocyte banking [ ]  Donor oocyte banking |
|  9A | **Indicate anticipated duration of oocyte banking SKIP IF EMBRYO BANKING ONLY**[ ]  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 |
| 9B | **Indicate anticipated duration of embryo banking SKIP IF OOCYTE BANKING ONLY**[ ]  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 |
| 10 | **Intended embryo source (select all that apply):**[ ]  Patient embryos[ ]  Donor embryos **[IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #12]** |
| 10A | **If intent is to use FRESH EMBRYOS, specify intended oocyte source. Select all that apply:**  [ ]  Patient oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes  [ ]  Donor oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes **If intent is to use FROZEN EMBRYOS, specify intended oocyte source. Select all that apply:**  [ ]  Patient oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes  [ ]  Donor oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes [ ]  Unknown (select only if oocyte source is unknown) |
| 11 | **Specify intended sperm source. Select all that apply. [SKIP IF DONOR EMBRYO IS INTENDED SOURCE]**[ ]  Partner[ ]  Donor[ ]  Patient, if male[ ]  Unknown (select only if all sperm sources unknown for frozen) |
| 12 | **Pregnancy carrier** [ ]  Patient [ ]  Gestational carrier [ ]  None (oocyte or embryo banking cycle only) |

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| CYCLE INFORMATION (NOT prosPEctive FROM HERE FORWARD) |
| **Quex ID** | **LEAD QUESTION** |
| 13 | **Type of ART performed? Select all that apply:**[ ]  IVF: Transcervical[ ]  GIFT: Gametes to tubes [ ]  ZIFT: Zygotes to tubes or TET: tubal embryo transfer[ ]  Oocyte or embryo banking |
| 14 | **Embryo source (select all that apply):**[ ]  Patient embryos[ ]  Donor embryos **[IF ONLY DONOR EMBRYOS SELECTED, SKIP TO #15]** |
| 14A | **If FRESH EMBRYOS were used, specify intended oocyte source. Select all that apply:**  [ ]  Patient oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes  [ ]  Donor oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes **If FROZEN EMBRYOS were used, specify intended oocyte source. Select all that apply:**  [ ]  Patient oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes  [ ]  Donor oocytes [ ]  Fresh oocytes [ ]  Frozen oocytes [ ]  Unknown (select only if oocyte source is unknown) |

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| **PATIENT MEDICAL EVALUATION** |
|  | REASON FOR ART  |
| **Quex ID** | **LEAD QUESTION** |
| 15 | **Reason for ART (Select all that apply):**[ ]  Male infertility (select all that apply) |
| **[SKIP IF MALE INFERTILITY NOT SELECTED]** | * Medical condition
* Genetic or chromosomal abnormality Specify\_\_\_\_\_\_\_\_\_\_\_
* Abnormal sperm parameters (select all that apply)

[ ]  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 historic hydrosalpinx)[ ]  Ovulatory disorders |
| **[SKIP IF OVULATORY DISORDER NOT SELECTED]** | [ ]  PCO [ ]  Other ovulatory disorders |
| [ ]  Diminished ovarian reserve[ ]  Uterine factor[ ]  Preimplantation Genetic Diagnosis 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 AND PHYSICAL  |
|  16 | **[IF SEX OF PATIENT = MALE (FROM QUESTION #5) THEN SKIP #16-23]****Height:** |\_\_| Feet and/or |\_\_|\_\_| Inches or |\_\_|\_\_|\_\_|\_\_| Centimetersor[ ]  Height unknown |
|  17 | **Weight at the start of this cycle**|\_\_|\_\_|\_\_|\_\_| Pounds or |\_\_|\_\_|\_\_|\_\_| Kilogramsor[ ]  Weight unknown |
|  18 | **History of cigarette smoking:**Did the patient smoke during the 3 months before the cycle started?[ ]  Yes [ ]  No [ ]  Unknown |
|  19 | **Any prior pregnancies?**  ⃝Yes  ⃝ 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 PREGNANCIES** | **If prior pregnancies reported, how many |\_\_|\_\_|**  |
|  19C | **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? ⃝Yes ⃝ No** |
|  22 | **Patient maximum FSH level (MIU/mls): |\_\_|\_\_|\_\_| . |\_\_|\_\_|**Or FSH unknown: [ ]  |
| 23 | **Most recent AMH level (ng/mL): |\_\_|\_\_|\_\_| . |\_\_|\_\_|** Or AMH unknown: [ ] **Date of most recent AMH level |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|** |
| **SOURCE AND CARRIER PROFILES** |
|  | **OOCYTE SOURCE PROFILE** |
| **Quex ID** | **LEAD QUESTION** |
| 24 | **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:**⃝ NOT Hispanic or Latino⃝ Hispanic or Latino⃝ Refused⃝ Unknown |
| 26 | **OOCYTE SOURCE Race (based on oocyte source self-report)****Select all that apply:**[ ]  White [ ]  Black or African American[ ]  Asian[ ]  Native Hawaiian or other Pacific Islander[ ]  American Indian or Alaska Native |
| 26A |  | **Select reason race not reported:**⃝ Refused⃝ Unknown |

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|  | PREGNANCY CARRIER PROFILE  |
| 27 | **Pregnancy carrier** [ ]  Patient [ ]  Gestational carrier [ ]  None (oocyte or embryo banking cycle only) |
| 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 \_\_\_\_** |
| 29 | **Pregnancy carrier Ethnicity:****Select one:**⃝ NOT Hispanic or Latino⃝ Hispanic or Latino⃝ Refused⃝ Unknown |
| 30 | **Pregnancy carrier Race (based on gestational carrier self report)****Select all that apply:**[ ]  White [ ]  Black or African American[ ]  Asian[ ]  Native Hawaiian or other Pacific Islander[ ]  American Indian or Alaska Native |
| 30A | Yes |  | **Select reason race not reported:**⃝ Refused⃝ Unknown |

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| **Quex ID** | **LEAD QUESTION** |
|  | SPERM SOURCE PROFILE  |
| 31 | **Specify sperm source. Select all that apply.** [ ]  Partner[ ]  Donor[ ]  Patient, if male[ ]  Unknown (select only if all sperm sources unknown for frozen) |
| 32 | **SPERM source Date of Birth (mm/dd/yyyy):**|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|  **[FIELD PRE-FILLED IF SPERM SOURCE=MALE PATIENT]**Or [ ]  Unknown |
| 33 | **SPERM source Ethnicity:****Select one:**⃝ NOT Hispanic or Latino⃝ Hispanic or Latino⃝ Refused⃝ Unknown |
| 34 | **SPERM source Race (based on patient self report)****Select all that apply:**[ ]  White [ ]  Black or African American[ ]  Asian[ ]  Native Hawaiian or other Pacific Islander[ ]  American Indian or Alaska Native |
| 34A |  | **Select reason race not reported:**⃝ Refused ⃝ Unknown |
| **STIMULATION AND RETRIEVAL** |
| **Quex ID** | **LEAD QUESTION** |
|  | **OVARIAN STIMULATION AND MEDICATIONS** |
| 35 | **Was there stimulation for follicular development?**  ⃝Yes ⃝ No**[IF NO STIMULATION OR FROZEN CYCLE, SKIP #36-39]** |
| 36 | **Oral medication such as aromatase inhibitor or selective estrogen receptor modulator?** ⃝Yes ⃝ No  |
| 36A | **[SKIP IF NO ORAL MEDS]** | **Clomiphene dosage (Total mgs): |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|****Letrozole dosage (Total mgs) |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|****Other (specify)\_\_\_\_\_\_\_\_\_ dosage |\_\_|\_\_|\_\_|\_\_|\_\_| . |\_\_|\_\_|** |
| 37 | **Medication(s) containing FSH?**  **⃝Yes ⃝ 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?**  **⃝Yes ⃝ No**  |
| **Quex ID** | **LEAD QUESTION** |
| 39 | **GnRH Protocol** **Select the one primary protocol:****⃝** No GnRH protocol**⃝** GnRH Agonist Suppression**⃝** GnRH Agonist Flare**⃝** 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?**  **⃝**Yes ⃝ No |
| 40A | **[SKIP IF CYCLE NOT CANCELLED]** | **Date cycle canceled (mm/dd/yyyy): |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|** |
| 40B | **Select one primary reason cycle was canceled:**  **[ ]  Low ovarian response** **[ ]  High ovarian response** **[ ]  Inadequate endometrial response** **[ ]  Concurrent illness** **[ ]  Withdrawal only for personal reasons** **[ ]  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 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 |
| 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?** **⃝**Yes ⃝ No |
| 45A | **SKIP IF NO COMPLICATIONS** | **Select all complications that apply:**[ ]  Infection[ ]  Hemorrhage requiring transfusion[ ]  Ovarian hyperstimulation requiring intervention or hospitalization[ ]  Medication side effect[ ]  Anesthetic complication[ ]  Thrombosis[ ]  Death of patient[ ]  Other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 45B | **SKIP IF NO COMPLICATIONS** | **Did the complication(s) require hospitalization?** ⃝Yes ⃝ No  |
|  | **[IF OOCYTE BANKING CYCLE ONLY, STOP HERE]** |

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|  | SPERM RETRIEVAL  |
| 46 | **Sperm status:** [ ] Fresh[ ]  Thawed[ ] Mix of fresh and thawed |
| 47 | **Sperm source utilized:****⃝** Ejaculated**⃝** Epididymal **⃝** Testis**⃝** Electroejaculation**⃝** Retrograde urine**⃝** Donor**⃝** Unknown |
| **LABORATORY INFORMATION** |
| **Quex ID** | **LEAD QUESTION** |
|  | MANIPULATION  |
| 48 | **Intracytoplasmic sperm injection (ICSI) performed on oocytes?****⃝** All oocytes**⃝** Some oocytes**⃝** No oocytes**⃝** Unknown |
| 48A | **SKIP IF NO ICSI** | **Indication for ICSI (select all that apply)****⃝** Prior failed fertilization**⃝** Poor fertilization**⃝** PGD**⃝** Abnormal semen parameters on day of fertilization **⃝** Low oocyte yield**⃝** Laboratory routine**⃝** Frozen cycle**⃝**  Rescue ICSI**⃝** Other – specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 49 | **In vitro maturation (IVM) performed on oocytes?****⃝** All oocytes**⃝** Some oocytes**⃝**  No oocytes**⃝** Unknown |
| 50 | **Pre-implantation genetic diagnosis or screening performed on embryos?**⃝ Yes⃝ No⃝ Unknown  |
| 50A | **SKIP IF PGD/PGS NOT PERFORMED OR UNKNOWN** | **Total number of 2PN:** |\_\_|\_\_| |
| 50B | **Reason(s) for pre-implantation genetic diagnosis or screening (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 |
| 50C | **Technique(s) used for pre-implantation genetic diagnosis or screening (Select all that apply):**[ ]  Polar Body Biopsy[ ]  Blastomere Biopsy[ ]  Blastocyst Biopsy[ ]  Unknown |
| 51 | **Assisted hatching performed on embryos?****⃝** All embryos⃝ Some embryos**⃝** No embryos⃝ Unknown |
|  52 | **Was this a research cycle?****⃝** Yes Enter SART approval code\_\_\_\_\_\_\_\_\_\_\_\_\_⃝ No |
| 52A | **SKIP IF NOT RESEARCH CYCLE** | **Study type:**[ ]  Device study[ ]  Protocol study[ ]  Pharmaceutical study[ ]  Laboratory technique[ ]  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?** ⃝Yes ⃝ No  |
| 53A |  | **Select one 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 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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|  | **[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 one fresh embryo was transferred to the uterus, was this an elective single embryo transfer?** ⃝Yes ⃝ No  |
| 58A-X | **Quality of embryo #1–X****[ ]** Good[ ]  Fair[ ]  Poor[ ]  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 | **[SKIP #63 FOR MIXED CYCLE]****If only one thawed embryo was transferred to the uterus, was this an elective single embryo transfer?** ⃝Yes ⃝ No  |
| 62A-X | **Quality of embryo #1–X**[ ] Good[ ]  Fair[ ]  Poor[ ]  Unknown |
|  |  | **Date of oocyte retrieval for embryo #1-X |\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|** |
| 63 | **Number of THAWED embryos cryopreserved (re-frozen): |\_\_|\_\_|** |
|  | GIFT/ZIFT/TET TRANSFER DETAILS |
| 64 | **[SKIP IF IVF CYCLE]****Number of oocytes or embryos transferred to the FALLOPIAN TUBE: |\_\_|\_\_|** |

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| **TREATMENT OUTCOME (only opens if transfer >0)** |
| **Quex ID** | **LEAD QUESTION** |
|  | OUTCOME OF TRANSFER |
| 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]** |
| 66 |  | **Maximum fetal hearts on ultrasound performed before 7 weeks or prior to reduction: |\_\_|\_\_|**[ ]  **No ultrasound performed before 7 weeks gestation** |
| 66A | **[SKIP IF NO U/S]** | **Date ultrasound with max. number of fetal hearts observed before 7 weeks (mm/dd/yyyy):** **|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|** |
| 66B | **[SKIP IF NO U/S]** | **If 2 or more fetal hearts, any monochorionic twins or multiples? ⃝Yes ⃝ No ⃝Unknown**  |
| **PREGNANCY OUTCOME (only opens if pregnancy = yes)** |
| **Quex ID** | **LEAD QUESTION** |
|  | OUTCOME OF PREGNANCY |
| 67 | **Outcome of pregnancy:** **[ ]** Live birth [ ]  Spontaneous abortion[ ]  Stillbirth[ ]  Induced abortion[ ]  Maternal death prior to birth[ ]  Outcome unknown |
| 68 | **Date of pregnancy outcome (mm/dd/yyyy):** **|\_\_|\_\_| - |\_\_|\_\_| - |\_\_|\_\_|\_\_|\_\_|****NOTE: If multiple births cover more than one date, enter date of first born.** |
| 68A | **Method of delivery****[ ]  Vaginal** **[ ]  Cesarean section** |
| 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 |
|  | BIRTH INFORMATION |
| 70 | **Number of infants born: |\_\_|\_\_|**  |
| 71A-X | **Birth Status infant #1-X**[ ]  Live birth[ ]  Stillbirth[ ]  Unknown |
| 72A-X | **Gender infant #1-X**[ ]  Male[ ]  Female[ ]  Unknown |
| 73A-X | **Weight in pounds and ounces, or grams infant #1-X****|\_\_|\_\_| lbs and |\_\_|\_\_| oz. OR |\_\_|\_\_|\_\_|\_\_| g****OR****[ ]  Weight unknown** |
| 74A-X | **Birth defects (select all that apply) infant #1-X****[ ]** None[ ]  Cleft lip/palate[ ]  Genetic defect/chromosomal abnormality[ ]  Neural tube defect[ ]  Cardiac defect[ ]  Limb defect[ ] Other (specify) OR [ ] Unknown |
| 75A-X | **For liveborn infant, did neonatal death occur? infant #1-X**[ ]  Yes[ ]  No[ ] Unknown |