

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM ONE: PATIENT INFORMATION

### Patient Demographic Section

Last Name:  First Name:  MI:

Social Sec #:  Ethnicity:

Date of Birth:  /  /  Clinic Patient ID:

Mo Day Year

### Select all that apply

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Unknown / Not Observed

### Partner Demographic Section

Last Name:  First Name:  MI:

Sperm Donor Identity Unkown:  Ethnicity:

### Select all that apply

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Unknown / Not Observed

### Patient Residency Section

US Resident:  Yes  No Zip Code:

City:  State:  Country:

### Patient Contact Section (Optional)

Address:

Home Phone: (  ) -  Work Phone: (  ) -

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM TWO: PATIENT HISTORY

### Couple Information Section

Pt. Name:

Pt. Social Sec #:

Date of Birth:

Partner Name:

### Clinic Index Section

Clinic Cycle ID:

Clinic Patient ID:

### Patient History Section

Gravidity:

Prior Full Term ( $\geq 37$  wks) Births:

Prior Preterm ( $< 37$  wks) Births:

Prior Spontaneous Abortions:

Surgical Sterilization:

 Yes  No  Unknown

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM THREE: PATIENT DIAGNOSIS

Patient Name:

Clinic Cycle ID:

### Prior Treatment Section

Prior Gonadotropin Cycles:

Prior Frozen ART Cycles (transfers):

Prior Fresh ART Cycles (starts):

### FSH Section

Patient Maximum FSH:  mIU/ml  Unknown Lab Upper Normal  mIU/ml

### Reason for ART Section (check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Male Infertility                                | <input type="checkbox"/> Tubal                                    | <input type="checkbox"/> Uterine Factor |
| <input type="checkbox"/> History of Endometriosis                        | <input type="checkbox"/> Tubal ligation, not reversed             | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Ovulation Disorders /<br>Polycystic Ovaries PCO | <input type="checkbox"/> Hydrosalpinx (in place)                  | <input type="checkbox"/> Unexplained    |
| <input type="checkbox"/> Diminished Ovarian Reserve                      | <input type="checkbox"/> Other tubal disease (no<br>hydrosalpinx) |   |

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM FOUR: ART TREATMENT

Patient Name:

Clinic Cycle ID:

### Patient Medication Section

Cycle Start Date:  Clomiphene:   Total mgs  Agonist flare  
 Agonist suppression  
 Unstimulated FSH:   Total IUs  Antagonist suppression

### ART Treatment Section

<b>Oocyte Source</b> <input type="checkbox"/> Autologous (Patient) <input type="checkbox"/> Donor Oocyte <input type="checkbox"/> Donor Embryo	<b>Oocyte State</b> <input type="checkbox"/> Fresh <input type="checkbox"/> Thawed	<b>Transfer Method</b> <input type="checkbox"/> Transcervical (IVF) <input type="checkbox"/> Zygotes to Tubes (ZIFT) <input type="checkbox"/> Gametes to Tubes (GIFT)
Gestational Carrier: <input type="checkbox"/> Embryo Banking: <input type="checkbox"/> Approved Research: <input type="checkbox"/>		
Treatment Occurred as Intended: <input type="checkbox"/> Yes <input type="checkbox"/> No		

### Cancellation and Complications Section

Cycle Cancelled:  Cycle Cancel Date:  Reason Cancelled:   
 Complications Related to:  Hospitalization Occurred:  Yes  No

- Select complications or none if none**
- |   |   |
|---|---|
| <input type="checkbox"/> None                             | <input type="checkbox"/> Anaesthetic complication |
| <input type="checkbox"/> Hemorrhage requiring transfusion | <input type="checkbox"/> Psychological stress     |
| <input type="checkbox"/> Moderate Hyperstimulation        | <input type="checkbox"/> Infection                |
| <input type="checkbox"/> Severe Hyperstimulation          | <input type="checkbox"/> Death                    |
| <input type="checkbox"/> Medication side effect           | <input type="checkbox"/> Other                    |

- Select one (Only) if cancelled cycle = Yes**
- Low Response (Fresh Only)
  - High Response (Fresh Only)
  - Failure to Survive Thaw (Frozen Only)
  - Inadequate Endometrial Response (Frozen Only)
  - Concurrent Illness
  - Withdrawal (Psychological)
  - Withdrawal (Financial)
  - Withdrawal (Family)
  - Withdrawal (Other)

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM FIVE: DONOR AND RETRIEVAL DATA

Patient Name:

Clinic Cycle ID:

### Donor Medication Section

Donor ID #:

Clomiphene:   Total mgs

Agonist flare

Agonist suppression

Unstimulated

FSH:   Total IUs

Antagonist suppression

### Retrieval Section

Pt. Retrieval Date:

Oocytes Retrieved (Pt):

Embryos Thawed:

Dnr. Retrieval Date:

Oocytes Retrieved (Dnr.):

Donor Shared:

### Andrology Section

Sperm Source:

Collection Method:

#### Select one

- Partner
- Donor
- Mixed

#### Select one

- Ejaculation
- Aspiration
- Biopsy
- Electroejac.
- Retrograde Ejac.

### Micromanipulation Section

ICSI:

PGD:

Assisted Hatching:

#### Select one

- All Mature Oocytes
- Some Oocytes
- None

#### Select one

- All Transferred Embryos
- Some Embryos
- None

#### Select one

- All Transferred Embryos
- Some Embryos
- None

**SART CORS VERSION 8 DATA COLLECTION FORMS**  
**FORM SIX: TRANSFER AND OUTCOME DATA**

Patient Name:

Clinic Cycle ID:

**Transfer Section**

Transfer Attempted:

Transfer Date:

# of Fresh Embryos to Uterus:

# of Oocytes to Tubes:

# of Fresh Embryos to Tubes:

# of Fresh Embryos Cryopreserved:

**Thawed Transfer Section**

# of Thawed Embryos to Uterus:

# of Thawed Embryos Re-Frozen:

# of Thawed Embryos to Tubes:

**Treatment Outcome Section**

Outcome of Treatment:

U/S Test Performed:

U/S Date:

Max. Fetal Hearts (on U/S):

Therapeutic Reduction : Yes No Unk

Therapeutic Reduction Date:

**Select one**

- Not Pregnant
- Biochemical
- Ectopic
- Clinical Intrauterine Gestation
- Heterotopic
- Unknown

# SART CORS VERSION 8 DATA COLLECTION FORMS

## FORM SEVEN: DELIVERY INFORMATION

Patient Name:

Clinic Cycle ID:

### Pregnancy Outcome Section

Outcome of Pregnancy:

Date of Outcome:

Information Source:

Number Born:

**Select one**

- Livebirth
- Stillbirth
- Spontaneous Abortion
- Therapeutic Abortion
- Maternal Death Prior to Birth
- Outcome Unknown

Only required for cycle starts after 12/31/2002  
F for Female  
S for Stillbirth  
Or  
Unk for Unknown

### Birth Section

LBs/Ozs

Grms Ozs

Weight

Circle one

Neonatal Death

Live / Still

Gender

Birth Defects

Death

	Live / Still	Gender	Grms Ozs	Birth Defects	Neonatal Death
One:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No
Two:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No
Three:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No
Four:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No
Five:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No
Six:	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 80px; height: 20px;" type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> Unk <input type="checkbox"/> No

**Select one**

- Patient (verbal only)
- Patient (written)
- Attending physician or hospital (verbal only)
- Attending physician or hospital (written)

L for Live Birth  
or  
S for Stillbirth

**Indicate all that apply for each infant born**

- None or Unknown, or
- Genetic Defect
- Cleft Lip or Palate
- Neural Tube Defect
- Cardiac Defect
- Limb Defect
- Other Defect

Pounds in this box

Ounces or grams in this box