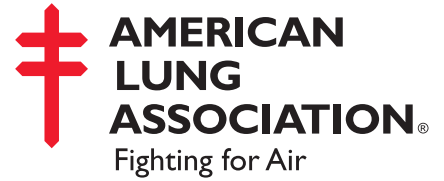


MY COPD ACTION PLAN

It is recommended that patients and physicians /healthcare providers complete this action plan together. This plan should be discussed at each physician visit and updated as needed.



The green, yellow and red zones show groups of symptoms of COPD. The list of symptoms is not comprehensive, and you may experience other symptoms. In the “Actions” column, your healthcare provider will recommend actions for you to take based on your symptoms by checking the appropriate boxes. Your healthcare provider may write down other actions in addition to those listed here.

Green Zone: I am doing well today	Actions
<ul style="list-style-type: none"> • Usual activity and exercise level • Usual amounts of cough and phlegm/mucus • Sleep well at night • Appetite is good 	<ul style="list-style-type: none"> <input type="checkbox"/> Take daily medicines <input type="checkbox"/> Use oxygen as prescribed <input type="checkbox"/> Continue regular exercise/diet plan <input type="checkbox"/> At all times avoid cigarette smoke, inhaled irritants* <input type="checkbox"/> _____ <input type="checkbox"/> _____

Yellow Zone: I am having a bad day or a COPD flare	Actions
<ul style="list-style-type: none"> • More breathless than usual • I have less energy for my daily activities • Increased or thicker phlegm/mucus • Using quick relief inhaler/nebulizer more often • Swelling of ankles more than usual • More coughing than usual • I feel like I have a “chest cold” • Poor sleep and my symptoms woke me up • My appetite is not good • My medicine is not helping 	<ul style="list-style-type: none"> <input type="checkbox"/> Continue daily medication <input type="checkbox"/> Use quick relief inhaler every _____ hours <input type="checkbox"/> Start an oral corticosteroid (specify name, dose and duration) <input type="checkbox"/> _____ <input type="checkbox"/> Start an antibiotic (specify name, dose and duration) <input type="checkbox"/> _____ <input type="checkbox"/> Use oxygen as prescribed <input type="checkbox"/> Get plenty of rest <input type="checkbox"/> Use pursed lip breathing <input type="checkbox"/> At all times avoid cigarette smoke, inhaled irritants* <input type="checkbox"/> Call provider immediately if symptoms don't improve*

Red Zone: I need urgent medical care	Actions
<ul style="list-style-type: none"> • Severe shortness of breath even at rest • Not able to do any activity because of breathing • Not able to sleep because of breathing • Fever or shaking chills • Feeling confused or very drowsy • Chest pains • Coughing up blood 	<ul style="list-style-type: none"> <input type="checkbox"/> Call 911 or seek medical care immediately <input type="checkbox"/> While getting help, immediately do the following: <input type="checkbox"/> _____ <input type="checkbox"/> _____

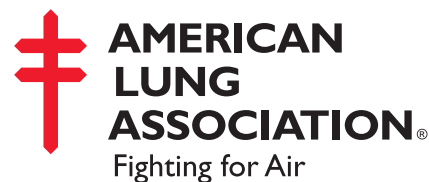
*The American Lung Association recommends that the providers select this action for all patients.

The information contained in this document is for educational use only. It should not be used as a substitute for professional medical advice, diagnosis or treatment.

For more information, visit www.Lung.org or call 1-800-LUNG-USA (1-800-586-4872)

MY COPD ACTION PLAN

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General Information	
Name:	
Emergency Contact:	Phone Number:
Physician/Health Care Provider Name:	Phone Number:
Date:	

Lung Function Measurements		
Weight: _____ lbs	FEV1: _____ L _____ % predicted	Oxygen Saturation: _____ %
Date:	Date:	Date:

General Lung Care		
Flu Vaccine	Date:	Next Flu Vaccine Due:
Pneumonia vaccine	Date:	Next Pneumonia Vaccine Due:
Smoking status	<input type="checkbox"/> Never <input type="checkbox"/> Past <input type="checkbox"/> Current	Quit Smoking Plan
Exercise plan <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Walking <input type="checkbox"/> Other _____ _____ min/day _____ days/week	Pulmonary Rehabilitation <input type="checkbox"/> Yes <input type="checkbox"/> No
Diet plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Goal Weight: _____	

Medications for COPD			
Type or Descriptions of Medicines	Name of Medicine	How Much to Take	When to Take

My Quit Smoking Plan		
<input type="checkbox"/> Advise: Firmly recommend quitting smoking	<input type="checkbox"/> Discuss use of medications, if appropriate:	
<input type="checkbox"/> Assess: Readiness to quit		
<input type="checkbox"/> Encourage: To pick a quit date	<input type="checkbox"/> Freedom From Smoking® www.ffsonline.org	<input type="checkbox"/> Lung HelpLine 1-800-LUNG USA
<input type="checkbox"/> Assist: With a specific cessation plan that can include materials, resources, referrals and aids		

Oxygen		
Resting:	Increased Activity:	Sleeping:

Advanced Care and Planning Options				
<input type="checkbox"/> Lung Transplant	<input type="checkbox"/> Lung Reduction	<input type="checkbox"/> Transtracheal Oxygen	<input type="checkbox"/> Night-time Ventilator	<input type="checkbox"/> Advanced Directives

Other Health Conditions			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety/Panic	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> GERD/Acid Reflux
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Kidney/Prostate
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other:		