

MY COPD ACTION PLAN

Actions to take if my symptoms get worse

This plan is to be completed by patients with the help of their physician/health care provider. The patient should bring this form to each doctor appointment and update as needed.

This symptom list below is comprehensive but you may experience other symptoms. If you are unclear as to the actions you should take, please contact your physician/health care provider.

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"> • Take daily medicines • Use oxygen as prescribed • Continue regular exercise/diet plan • At all times avoid cigarette smoke, inhaled irritants

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 • Change in color of 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"> • Continue daily medications • Use quick relief inhaler every _____ hours • Start Prednisone: _____ • Start Antibiotic: _____ • Use oxygen as prescribed • Get plenty of rest • Use pursed lip breathing • At all times avoid cigarette smoke, inhaled irritants • Call provider if symptoms don't improve

* Please call your physician immediately if your symptoms persist (see Red Zone below).

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"> • Call 911 or have someone take you to the emergency room • Increase oxygen to: _____ • Take Prednisone: _____

For more information visit www.lungusa.org or call 1-800-LUNGUSA (586-4872)

MY COPD MANAGEMENT PLAN

This plan is to be completed by patients with the help of their physician/health care provider. The patient should bring this form to each doctor appointment and update as needed.

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 Health 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
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:	

Inhaled Daily Medicines			
	Name of Medicine	How Much to Take	When to Take It
Quick Relief			
Long Acting			
Inhaled Steroid			
Combination			
Nebulizer			

Other Medicines for COPD			
	Name of Medicine	How Much to Take	When to Take It
Quit Smoking Aid			
Other			

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:		