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.

AMERICAN LUNG ASSOCIATION®
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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
• Usual activity and exercise level • Usual amounts of cough and phlegm/mucus • Sleep well at night • Appetite is good	☐ 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
• 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	☐ Continue daily medicati ☐ Use quick relief inhaler every _____ hours ☐ Start an oral corticosteroid (specify name, dose and duration) ☐ _____ ☐ Start an antibiotic (specify name, dose and duration) ☐ _____ ☐ Use oxygen as prescribed ☐ Get plenty of rest ☐ Use pursed lip breathing ☐ At all times avoid cigarette smoke, inhaled irritants* ☐ Call provider immediately if symptoms don't improve*

Red Zone: I need urgent medical care	Actions
• 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	☐ Call 911 or seek medical care immediately ☐ While getting help, immediately do the following: ☐ _____ ☐ _____

*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)

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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	☐ Never ☐ Past ☐ Current	Quit Smoking Plan
Exercise plan ☐ Yes ☐ No	☐ Walking ☐ Other_____ _____ min/day _____ days/week	Pulmonary Rehabilitation ☐ Yes ☐ No
Diet plan ☐ Yes ☐ 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

☐ **Advise:** Firmly recommend quitting smoking	☐ **Discuss use of medications, if appropriate:**	
☐ **Assess:** Readiness to quit		
☐ **Encourage:** To pick a quit date	☐ **Freedom From Smoking®** www.ffsonline.org	☐ **Lung HelpLine** 1-800-LUNG USA
☐ **Assist:** With a specific cessation plan that can include materials, resources, referrals and aids		

Oxygen

Resting:	Increased Activity:	Sleeping:

Advanced Care and Planning Options

☐ Lung Transplant	☐ Lung Reduction	☐ Transtracheal Oxygen	☐ Night-time Ventilator	☐ Advanced Directives

Other Health Conditions

☐ Anemia	☐ Anxiety/Panic	☐ Arthritis	☐ Blood Clots
☐ Cancer	☐ Depression	☐ Diabetes	☐ GERD/Acid Reflux
☐ Heart Disease	☐ High Blood Pressure	☐ Insomnia	☐ Kidney/Prostate
☐ Osteoporosis	☐ Other:		