American Lung Association.

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 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 medication ☐ 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.

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MY COPD **MANAGEMENT PLAN**

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

General Information

Name: _____ Date: _____

Emergency Contact: _____ Phone Number: _____

Physician/Health Care Provider Name: _____ Phone Number: _____

Lung Function Measurements

Weight: _____ lbs	FEV1: _____ L _____ % predicted	Oxygen Saturation: _____ %
Date: _____	Date: _____	Date: _____

General Lung Care

Flu vaccine _____	Date received: _____	Next Flu vaccine due: _____
Pneumococcal conjugate vaccine (PCV13) ☐ Yes ☐ No	Date received: _____	Next PCV13 vaccine due: _____
Pneumococcal polysaccharide vaccine (PPSV23) ☐ Yes ☐ No	Date received: _____	Next PPSV23 vaccine due: _____
Smoking status	☐ Never ☐ Past ☐ Current	Quit Smoking Plan ☐ Yes ☐ No
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

☐ **Assess:** Readiness to quit

☐ **Encourage:** To pick a quit date

☐ Discuss use of medications, if appropriate: _____

☐ Freedom From Smoking® Lung.org/ffs

☐ 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

Advance Directives (incl. Healthcare Power of Attorney): _____

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: _____