

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

- Usual activity and exercise level
- Usual amounts of cough and phlegm/mucus
- Sleep well at night
- Appetite is good

Actions

- 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

- 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

Actions

- 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

- 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

Actions

- 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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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) <input type="checkbox"/> Yes <input type="checkbox"/> No	Date received: _____	Next PCV13 vaccine due: _____
Pneumococcal polysaccharide vaccine (PPSV23) <input type="checkbox"/> Yes <input type="checkbox"/> No	Date received: _____	Next PPSV23 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: _____	

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 Freedom From Smoking® Lung HelpLine
Lung.org/ffs 1-800-LUNG USA

Encourage: To pick a quit date

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: _____