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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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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Contact:</td>
<td>Phone Number:</td>
</tr>
<tr>
<td>Physician/Health Care Provider Name:</td>
<td>Phone Number:</td>
</tr>
</tbody>
</table>

### Lung Function Measurements

<table>
<thead>
<tr>
<th>Weight: ______ lbs</th>
<th>FEV1: ______ L ______ % predicted</th>
<th>Oxygen Saturation: ______ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Date:</td>
<td>Date:</td>
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</tbody>
</table>

### General Lung Care

- **Flu vaccine**
  - Date received: __________
  - Next Flu vaccine due: __________
- **Pneumococcal conjugate vaccine (PCV13)**
  - Date received: __________
  - Next PCV13 vaccine due: __________
- **Pneumococcal polysaccharide vaccine (PPSV23)**
  - Date received: __________
  - Next PPSV23 vaccine due: __________
- **Smoking status**
  - Date: __________
  - Quit Smoking Plan: Yes / No
- **Exercise plan**
  - Date: __________
  - Walking: Yes / No
- **Diet plan**
  - Date: __________
  - Goal Weight: ______

### Medications for COPD

<table>
<thead>
<tr>
<th>Type or Descriptions of Medicines</th>
<th>Name of Medicine</th>
<th>How Much to Take</th>
<th>When to Take</th>
</tr>
</thead>
<tbody>
<tr>
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### My Quit Smoking Plan

- **Advise:** Firmly recommend quitting smoking
- **Discuss use of medications, if appropriate:**
- **Assess:** Readiness to quit
  - Date: __________
  - Freedom From Smoking® Lung.org/ffs
- **Encourage:** To pick a quit date
  - Date: __________
- **Encourage:** To walk a specific cessation plan that can include materials, resources, referrals and aids
  - Date: __________

### 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:** __________

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