

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.

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. THE AMERICAN LUNG ASSOCIATION DOES NOT ENDORSE ANY PRODUCT, DEVICE OR SERVICE, INCLUDING ANY PARTICULAR COPD MEDICATION OR TREATMENT DEVICE. For more information, visit [www.Lung.org](http://www.Lung.org) or call 1-800-LUNG-USA (1-800-586-4872) © 2015 American Lung Association

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) <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: \_\_\_\_\_