AMERICAN LUNG ASSOCIATION®
Fighting for Air

MY COPD ACTION PLAN
Actions to take if my symptoms get worse

This plan is to be completed by patients with the help of their physician/health care provider. The patient should bring this form to each doctor appointment and update as needed.

This symptom list below is comprehensive but you may experience other symptoms. If you are unclear as to the actions you should take, please contact your physician/health care provider.

Green Zone: I am doing well today	Actions
• Usual activity and exercise level	• Take daily medicines
• Usual amounts of cough and phlegm/mucus	• Use oxygen as prescribed
• Sleep well at night	• Continue regular exercise/diet plan
• Appetite is good	• 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	• Continue daily medications
• I have less energy for my daily activities	• Use quick relief inhaler every _____ hours
• Increased or thicker phlegm/mucus	• Start Prednisone: _____
• Change in color of phlegm/mucus	• Start Antibiotic: _____
• Using quick relief inhaler/nebulizer more often	• Use oxygen as prescribed
• Swelling of ankles more than usual	• Get plenty of rest
• More coughing than usual	• Use pursed lip breathing
• I feel like I have a “chest cold”	• At all times avoid cigarette smoke, inhaled irritants
• Poor sleep and my symptoms woke me up	• Call provider if symptoms don’t improve
• My appetite is not good	
• My medicine is not helping	

* Please call your physician immediately if your symptoms persist (see Red Zone below).

Red Zone: I need urgent medical care	Actions
• Severe shortness of breath even at rest	• **Call 911 or have someone take you to the emergency room**
• Not able to do any activity because of breathing	• **Increase oxygen to: _____**
• Not able to sleep because of breathing	• **Take Prednisone: _____**
• Fever or shaking chills	
• Feeling confused or very drowsy	
• Chest pains	
• Coughing up blood	

For more information visit www.lungusa.org or call 1-800-LUNGUSA (586-4872)

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MY COPD MANAGEMENT PLAN

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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 Health Care

Flu vaccine	Date:	Next Flu Vaccine Due:
Pneumonia vaccine	Date:	Next Pneumonia 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:	

Inhaled Daily Medicines

	Name of Medicine	How Much to Take	When to Take It
Quick Relief			
Long Acting			
Inhaled Steroid			
Combination			
Nebulizer			

Other Medicines for COPD

	Name of Medicine	How Much to Take	When to Take It
Quit Smoking Aid			
Other			

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:		

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