

# COPD ACTION PLAN



Name: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

## Green Zone: Doing Well

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| <ul style="list-style-type: none"><li>■ I breathe as usual.</li><li>■ My sputum is the usual color.</li><li>■ I have usual amounts of sputum.</li><li>■ I can do my usual activities without tiring.</li><li>■ I can think clearly.</li></ul> | <p>Take usual medications as prescribed.</p> <p>Continue daily activities.</p> <p>Exercise ( _____ ) _____ minutes per day; use pursed lip breathing.<br/><small>Type of activity</small></p> <p>Stop smoking, make your home and car smoke-free, and avoid secondhand smoke.</p> |
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## Yellow Zone: Getting Worse

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| <ul style="list-style-type: none"><li>■ I am short of breath, wheeze, or cough more than usual.</li><li>■ I have unexplained change in weight and my feet/ankles are swollen.</li><li>■ I have noticed changes in my sputum (thicker, color, amount).</li><li>■ I am taking my rescue inhaler more than usual.</li><li>■ I am more tired and cannot do my usual activities.</li><li>■ I am not thinking clearly.</li></ul> | <p>Limit activities.</p> <p>Check oxygen system to make sure it is working properly.</p> <p>Check saturation, if you have pulse oximetry. Call provider if &lt; ____%.</p> <p>Do pursed lip breathing or relaxation exercises.</p> <p>Take antibiotics and/or oral steroids, if prescribed.</p> <p>Add _____, _____ mg/puffs, _____ times per day.</p> <p>Add _____, _____ mg/puffs, _____ times per day.</p> <p>Call provider (phone _____) if</p> <p>_____</p> <p>_____</p> <p>_____</p> |
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## Red Zone: Medical Alert

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| <ul style="list-style-type: none"><li>■ I have increased trouble breathing.</li><li>■ I have increased trouble coughing up sputum.</li><li>■ I cannot do usual activities.</li><li>■ I am sleepy and difficult to wake up.</li><li>■ I am confused.</li><li>■ I have slurred speech or feel faint.</li></ul> | <p>Call 911 or go to the emergency room if you</p> <ul style="list-style-type: none"><li>● continue to have trouble breathing</li><li>● are unable to speak</li><li>● have chest pain</li><li>● are frightened by not being able to breathe or by how tired you feel</li><li>● have slurred speech</li><li>● feel faint or do faint</li><li>● are suddenly confused</li></ul> |
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**MEDICATIONS**

Name/Strength	Date Prescribed	Dosage	When to Take

**OXYGEN**

Date Prescribed	Prescription

**OXIMETRY**

Date	Saturation	Liter Flow	Oxygen Delivery Unit

**SPIROMETRY**

Date	FEV <sub>1</sub>	FVC	FEV <sub>1</sub> /FEV Ratio

**VACCINES**

Name	Date
Influenza	
Pneumococcal	

Notes/Questions for Provider