

My COPD Action Plan

Complete this plan with your care team.

PATIENT NAME _____

DATE COMPLETED _____

Review this plan at every visit. Symptoms below are common examples, not a complete list — tell your care team about anything new or different for you.

GREEN ZONE — I am doing well today

SYMPTOMS MAY INCLUDE:

- Usual activity and exercise level
- Usual amount of cough and phlegm
- Sleeping well at night
- Appetite is good

ACTIONS:

- ☐ Take daily medicines as prescribed
- ☐ Use oxygen as prescribed
- ☐ Keep up your regular exercise and diet plan
- ☐ Avoid tobacco products and other inhaled irritants

☐ **THIS IS ME TODAY**

YELLOW ZONE — I am having a bad day or a flare-up

SYMPTOMS MAY INCLUDE:

- More breathless than usual
- Less energy for daily activities
- More, or thicker, phlegm/mucus
- Using quick-relief inhaler more often
- More swelling in ankles
- More coughing than usual, or a “chest cold” feeling
- Poor sleep, or symptoms waking you up
- Poor appetite, or your medicine isn't helping

ACTIONS:

- ☐ Continue your daily medicines
- ☐ Use quick-relief inhaler as directed below
- ☐ Use oxygen as prescribed and get extra rest
- ☐ Use pursed-lip breathing
- ☐ Avoid smoke, vaping, and other irritants
- ☐ Call your provider if symptoms don't improve

☐ **THIS IS ME TODAY**

QUICK-RELIEF INHALER EVERY ____ HOURS _____

ANTIBIOTIC (NAME / DOSE / DURATION) _____

ORAL STEROID (NAME / DOSE / DURATION) _____

RED ZONE — I need urgent medical care

SYMPTOMS MAY INCLUDE:

- Severe shortness of breath, even at rest
- Can't do any activity because of breathing
- Can't sleep because of breathing
- Fever or shaking chills
- Confusion or unusual drowsiness
- Chest pain, or coughing up blood

ACTIONS:

- ☐ **Call 911 or seek emergency care now.**

WHILE WAITING FOR HELP, ALSO: _____

ADDITIONAL INSTRUCTIONS FROM YOUR CARE TEAM: _____

My COPD Management Plan

GENERAL INFORMATION

NAME	DATE
EMERGENCY CONTACT	PHONE
CARE PROVIDER	PHONE

HEALTH ASSESSMENT

WEIGHT (LBS)	FEV1 % PREDICTED	O2 SAT. W/ EXERCISE
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Tested for Alpha-1? ☐ Yes ☐ No

GENERAL LUNG CARE

Tobacco use (incl. e-cigarettes): ☐ Never ☐ Past ☐ Current

Exercise plan: ☐ Yes ☐ No

PULMONARY REHAB — DATE LAST ATTENDED

Diet plan: ☐ Yes ☐ No

MEDICATIONS FOR COPD

PURPOSE	MEDICINE	HOW MUCH	WHEN
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OXYGEN

RESTING	INCREASED ACTIVITY	SLEEPING
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OTHER HEALTH CONDITIONS

☐ Anemia	☐ Anxiety/panic	☐ Arthritis
☐ Blood clots	☐ Cancer	☐ Depression
☐ Diabetes	☐ GERD/acid reflux	☐ Heart disease
☐ High blood pressure	☐ Insomnia	☐ Kidney/prostate
☐ Osteoporosis	☐ Sleep apnea	☐ Other

ADVANCE CARE PLANNING

ADVANCE DIRECTIVE / HEALTHCARE POWER OF ATTORNEY ON FILE