

My COPD Action Plan

Patients and healthcare providers should complete this action plan together. This plan should be discussed at each visit and updated as needed.

The green, yellow and red zones show symptoms of COPD. The list of symptoms is not complete. You may experience other symptoms. In the “Actions” column, your healthcare provider will recommend actions for you to take. 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
- ☐ Avoid tobacco product use and other 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
- More swelling in ankles
- 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
- ☐ Avoid secondhand smoke, e-cigarette aerosol, and other inhaled irritants
- ☐ Call provider immediately if symptoms do not 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:

- ☐ _____

General Information

Name: _____ Date: _____
 Emergency Contact: _____ Phone Number: _____
 Healthcare Provider Name: _____ Phone Number: _____

Weight: _____ lbs FEV1 % Predicted: _____ Oxygen Saturation at Exercise: _____ % Tested for Alpha-1?
 Date: _____ Date: _____ Date: _____ ☐ Yes ☐ No Date: _____

General Lung Care

Flu vaccine _____ Date received: _____ Next Flu vaccine due: _____
 Pneumococcal conjugate vaccine (PCV13) ☐ Yes ☐ No Date received: _____ Next PCV13 vaccine due: _____
 Pneumococcal polysaccharide vaccine (PPSV23) ☐ Yes ☐ No Date received: _____ Next PPSV23 vaccine due: _____
 COVID19 vaccine ☐ Yes ☐ No Tobacco use, including e-cigarettes ☐ Never ☐ Past ☐ Current
 Exercise plan ☐ Yes ☐ No ☐ Walking ☐ Other _____ min/day _____ days/week Pulmonary rehabilitation
 Date last attended: _____
 Diet plan ☐ Yes ☐ No Goal Weight: _____

Medications for COPD

Purpose of Medicine	Name of Medicine	How Much to Take	When to Take
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

My Quit Plan

☐ **Advise:** Firmly recommend quitting tobacco use ☐ 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 ☐ Sleep Apnea ☐ Other: _____