

COPD Action Plan

The single most important part of managing a respiratory condition is learning to recognize and act upon the warning signs that signal the onset of an exacerbation.

Discuss these guidelines with your doctor to ensure you understand exactly which medications are to be used when and share the game plan with your care team so that they know what to do in case of emergency.

Contact Info

Patient's Name _____
Physician's Name _____
Physician's Number _____

*** Insurance Info**

Provider's Name _____
Provider's Number _____
Policy Number _____

Green - You're in the Clear



My breathing is normal
I was able to sleep
My appetite is normal
Coughing is under control
Mucus is normal in thickness, volume, and color

Action to Take

- Take medications as prescribed
- Use oxygen as directed
- Eat and sleep regularly
- Avoid airborne triggers
- Attend regular doctor visits

Yellow - Caution is Required



I have a fever
I used my rescue medication without relief
Mucus has changed amount, thickness, or color
I did not sleep well or have increased fatigue
I am more short of breath than usual
I'm experiencing swelling in feet or ankles
I feel like I'm getting sick

Action to Take

- Limit activity
 - Practice breathing control
 - Report these changes to my doctor today
 - Start special or rescue medications as prescribed
- The medications and dosages are:

Red - Get Help Right Away



I'm disoriented or confused
My speech is slurred
I have chest pain
I have severe shortness of breath
My fingertips or lips are blue
I coughed up blood

Action to Take

- Call 911 immediately or go to Emergency Care
 - Use special or rescue medications as prescribed
- The medications and dosages are:

Medication Information

Type of Medication	Name of Medication	How Much is Each Dose	When/How Often

Lung Function Measurements

Date _____

Date _____

Date _____

Weight _____ lbs

FEV1 _____ L _____ predicted

Oxygen Saturation Goal _____%

Oxygen Flow Setting

Continuous / Pulse Resting _____ Increased Activity _____ Sleeping _____

Other Health Conditions

Advanced Directive Contact Information

Advanced Directive Contact or Power of Attorney: Name: _____ Phone _____