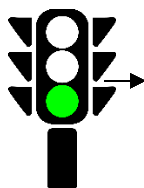
MY COPD ACTION PLAN

Contact your health care provider or doctor if you have any questions or you are unsure what action to take!

My name: ______________________ Date of birth: ____________ Today's date: _________

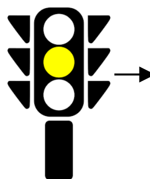


I Feel Well

- ☐ Usual activity level and appetite
- ☐ Usual amount and color of mucus
- ☐ Sleeping well or as usual

Take Action

- → Take daily medicines as directed
- → Use oxygen as directed
- → Do normal activities
- → Avoid all tobacco smoke or anything that makes me feel worse



I Don't Feel Well

- ☐ More short of breath than usual
- ☐ More and/or thicker mucus

If both checked and any one or more below are checked, Take Action

- ☐ Taking more reliever medicines
- ☐ Not much energy, poor appetite
- ☐ Not sleeping well, symptoms wake me
- ☐ New or more ankle swelling

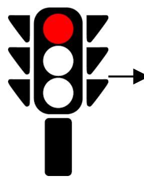
Take Action

- → Call my health care provider
- → Use daily medicines and oxygen as directed
- → Use quick relief inhaler or nebulizer
- → **Start Prednisone ***

____

*avoid NSAIDS (Advil, Motrin, Aleve or ibuprofen)

- → **Start antibiotic**________________________
- → Rest and use pursed lip breathing
- → Avoid all tobacco smoke or things that makes me feel worse



I Feel Much Worse

- ☐ Severe shortness of breath
- ☐ Chest pain
- ☐ Confused, slurring of speech or drowsy
- ☐ Not able to sleep
- ☐ Coughing up blood

Take Action

- → Call 911 or have someone bring me to the emergency room
- → Increase oxygen to:_____________________
- → Take emergency dose of Prednisone:

____

My doctor/healthcare provider: ______________________________ Phone #______________________

Lung specialist/pulmonary:_________________________________ Phone #______________________

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My COPD Action Plan: Page 2

- Fill this form out with your health care provider and update as needed.
- Keep this visible for quick reference, such as on your refrigerator.

Date: ______________ **Completed by:** ________________________________

My COPD Medicines

Name	Number of puffs or pills	How often	What it's for

My COPD classification: ☐ mild ☐ moderate ☐ severe ☐ very severe

My Lung Health Tests

Date	Weight	FEV_1 Liters	% Predicted	Oxygen or O_2 Saturation	Where tests were done

My Plan for Staying Well

1. Get annual flu vaccine (shot) ☐ Yes ☐ No Date______________
2. Get pneumonia vaccines (shot) ☐ Yes ☐ No Date______________
3. Attend pulmonary rehab program ☐ Yes ☐ No Date______________

4. Ways I can move more each day ☐ Yes ☐ No Plan:__________________________________
5. Ways I can eat healthier each day ☐ Yes ☐ No Plan:__________________________________

My Other Health Conditions

☐ Asthma ☐ Cancer ☐ GERD ☐ Osteoporosis ☐ Anemia ☐ Heart failure
☐ Anxiety/panic ☐ Heart attack ☐ Sleep apnea ☐ Depression ☐ Arthritis ☐ High blood pressure
☐ Stroke ☐ Diabetes ☐ High Cholesterol ☐ Tobacco use/dependence
☐ past ☐ current (counsel)

My Other Medicines

Name	Number of puffs or pills	How often	What it's for

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