

My COPD Action Plan

(Patient's Name)

Date



Canadian Respiratory
Guidelines



This is to tell me how I will take care of myself when I have a COPD flare-up.






My goals are _____

My support contacts are _____

(Name & Phone Number)

and _____

(Name & Phone Number)

My Symptoms	I Feel Well 	I Feel Worse 	I Feel Much Worse 
I have sputum.	My usual sputum colour is: _____	Changes in my sputum, for at least 2 days. OR More short of breath than usual for at least 2 days. Yes <input type="checkbox"/> No <input type="checkbox"/>	My symptoms are not better after taking my flare-up medicine for 48 hours. I am very short of breath, nervous, confused and/or drowsy, and/or I have chest pain. 
I feel short of breath.	When I do this: _____	If I checked 'Yes' to one or both of the above, I use my prescriptions for COPD flare-ups.	I will call my support contact and/or see my doctor and/or go to the nearest emergency department.
My Actions	Stay Well I use my daily puffers as directed.	Take Action I use my daily puffers as usual. If I am more short of breath than usual, I will take _____ puffs of _____ up to a maximum of _____ times per day.	I will dial 911. 
	If I am on oxygen, I use _____ L/min.	I use my breathing and relaxation methods as taught to me. I pace myself to save energy. If I am on oxygen, I will increase it from _____ L/min to _____ L/min.	Important information: I will tell my doctor, respiratory educator, or case manager within 2 days if I had to use any of my flare-up prescriptions. I will also make follow-up appointments to review my COPD Action Plan twice a year.
Notes:			

My COPD Action Plan

Physician's Copy

Date _____



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This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are _____

My support contacts are _____

(Name & Phone Number)

and _____

(Name & Phone Number)

Prescriptions for COPD flare-up (Patient to fill as needed for symptoms)

These prescriptions may be refilled two times each, as needed, for 1 year, to treat COPD flare-ups. Pharmacists may fax the doctor's office once any part of this prescription has been filled.

Patient's Name _____

Patient Identifier (e.g. DOB, PHN) _____

1. (A) If the colour of your sputum **CHANGES**, start antibiotic _____
How often _____ for #days: _____

Dose: _____ #pills: _____

(B) If the first antibiotic was taken for a flare-up in the last 3 months, use this different antibiotic instead:

Start antibiotic _____
How often _____ for #days: _____

Dose: _____ #pills: _____

AND / OR

2. If you are **MORE short of breath** than usual, start prednisone _____
How often: _____ for #days: _____

Dose: _____ #pills: _____

Once I start any of these medicines, I will tell my doctor, respiratory educator, or case manager within **2 days**.

Doctor's Name _____

Doctor's Fax _____

Doctor's Signature _____

License _____

Date _____