



My Plan of Action for COPD

Flu Vaccine Date: _____ Pneumonia Vaccine Date: _____ My Case Manager's Name is: _____ Phone: _____

<p>My Symptoms:</p> <p><input type="checkbox"/> I sleep well & my appetite is good</p> <p><input type="checkbox"/> Breathing is normal for me</p> <p><input type="checkbox"/> I can think clearly</p> <p><input type="checkbox"/> I can do usual activities</p>	<p>Green Zone</p> <p>This is a good day for me!</p> 	<p>My Action:</p> <p><input type="checkbox"/> <u>I take</u> my medicine as ordered by my doctor</p> <p><input type="checkbox"/> <u>I eat</u> healthy foods</p> <p><input type="checkbox"/> <u>I do</u> my exercises regularly</p> <p><input type="checkbox"/> <u>I avoid</u> things that make my symptoms worse</p> <p><input type="checkbox"/> <u>I make</u> sure I get the flu & pneumonia vaccine</p>
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<p>My Symptoms:</p> <p><input type="checkbox"/> I am more short of breath than usual or I have chest tightness</p> <p><input type="checkbox"/> I have more or thicker sputum/mucus or it is yellow or green</p> <p><input type="checkbox"/> I may have a wheeze or more coughing than usual</p> <p><input type="checkbox"/> I have more trouble doing normal activities</p> <p><input type="checkbox"/> I have a poor appetite</p> <p><input type="checkbox"/> I have trouble sleeping</p> <p><input type="checkbox"/> I feel restless</p> <p><input type="checkbox"/> I may have a fever</p> <p><input type="checkbox"/> I just don't feel "right"</p>	<p>Yellow Zone</p> <p>Could I have a respiratory infection?</p>  <p><i>* If I have <u>two or more</u> symptoms, <u>I will call my doctor.</u></i></p>	<p>My Action:</p> <p><input type="checkbox"/> <u>I will call</u> my doctor NOW</p> <p><input type="checkbox"/> <u>I will keep taking</u> my regular medicine</p> <p><input type="checkbox"/> <u>I will take</u> relief medicines my doctor told me to take</p> <p><input type="checkbox"/> <u>I will use</u> special breathing and relaxation techniques (purse lip breathing)</p> <p><input type="checkbox"/> <u>I will use</u> my oxygen as my doctor ordered (if ordered)</p> <p><input type="checkbox"/> <u>I will take</u> antibiotics if doctor orders them</p> <p>Doctor's # _____</p>
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<p>My Symptoms:</p> <p><input type="checkbox"/> I have a fever</p> <p><input type="checkbox"/> I have shortness of breath even at rest</p> <p><input type="checkbox"/> My medicine is not helping</p> <p><input type="checkbox"/> I feel confused, cannot talk well, I feel faint</p> <p><input type="checkbox"/> I have difficulty coughing up sputum or I have blood in my sputum</p>	<p>Red Zone</p> <p>I Need Help NOW!</p> 	<p>My Action:</p> <p><input type="checkbox"/> <u>I will</u> call my doctor NOW or have my family call for me</p> <p><input type="checkbox"/> If I cannot reach the doctor, <u>I will immediately call 911 or go to the nearest hospital emergency room</u></p> <p>Doctor's # _____</p>
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I have received smoking cessation counseling _____ I am interested in receiving smoking cessation counseling Yes No

Pt. Name: _____ DOB: _____ Date: _____

Physician: _____ Phone: _____

Carolina Community Health Partnership

Pt. Name: _____ DOB: _____ Date: _____

Physician: _____ Phone: _____

My Regular Medicines

Medication Name/Strength	Dose Puffs/Pills	How Often or How Many Times

My RELIEF Medicines

Medication Name/Strength	Dose Puffs/Pills	How Often or How Many Times

My Special Medicines

Medication Name/Strength	Dose Puffs/Pills	How Often or How Many Times

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