



COPD PLAN OF CARE

A Physician-Patient Coordinated Instrument

Patient's Name _____

Emergency Contact _____

Physician or Clinic _____

HAP Member ID Number _____

Date of Birth _____

Instruction Date _____

Phone Number _____

Phone Number _____

Phone Number _____

Tobacco User? Yes No

Circle Known Co-Morbidities

Asthma Diabetes Hypertension Depression Heart Disease Other _____

GREEN ZONE: USUAL TREATMENT WHEN STABLE

FEV_1 _____ %
 FVC _____ %
 FEV_1/FVC RATIO _____ %
 Stage 0, I, II, III, or IV? _____

Stage 0: At Risk
 Stage I: $FEV_1 > 80\%$
 Stage II: $50\% < FEV_1 < 80\%$
 Stage III: $30\% < FEV_1 < 50\%$
 Stage IV: $FEV_1 < 30\%$
 Stages I-IV: $FEV_1:FVC < 70\%$

Regular Medications	Strength	Dose	Route (MCI+Spacer, DPI, Nebulizer, Oral)	Frequency

YELLOW ZONE: MODERATE ATTACK OR WORSENING SYMPTOMS

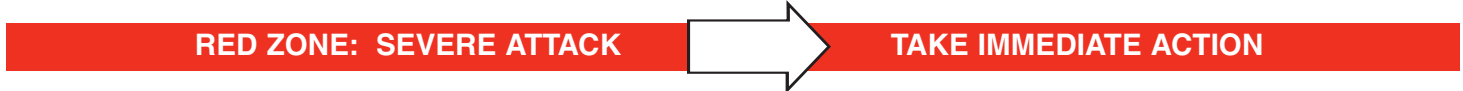
- More wheezing/shortness of breath
- Increased cough/sputum
- Change in sputum color
- Reduced energy, loss of appetite, poor sleep
- Rapid breathing

Helpful Hints

- Eat small amounts regularly
- Use controlled breathing techniques
- Use huff & puff cough to clear secretions
- Control anxiety/stress

Extra Reliever	Strength	Dose	Route	How Often

STEROID	Reducing Schedule	Strength	mg or Tablets/Dose	Days



- ➔ Call 911.
- ➔ Say, "I Can't Breathe."
- ➔ Give your address or location.
- ➔ Use _____ until help arrives.

Symptoms

- Can't catch your breath even at rest
- Blue tint to lips and fingernails
- Fever and chills
- Increased swelling of ankles



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SPIROMETRIC MEASUREMENTS

FEV1 (%)	FVC (%)	FEV1/FVC Ratio	Date Mo/Day/Yr	Smoking (Packs /Week)	Comments (i.e. pre- & post-bronchodilator)

OXYGEN USAGE & BODY MASS MEASUREMENTS

Date (Mo/Day/Yr)							
Pulse Oximetry Reading (%)							
Home Oxygen Usage (hrs/day)							
Body Weight (Lbs)							
Height (feet, inches)							
Body Mass Index							

ANTIBIOTIC & STEROID USAGE HISTORY

Antibiotic	Date (Mo/Day/Yr)	Oral & Inhaled Steroids	Date (Mo/Day/Yr)

ADDITIONAL MEDICAL HISTORY

Important Medical Facts	Date (Mo/Day/Yr)	Date (Mo/Day/Yr)	Description / Comments
Influenza Vaccine			
5-yr Pneumococcal Vaccine			
Hospitalizations			
Emergency Room Visits			
Skilled Care Nursing Visits			
Personal Care Physician Visits			
Other			

- ARE YOU ON:**
- A smoking cessation program?
 - A physician approved nutrition program?
 - A physician approved regular exercise program?
 - A chronic disease management program with a Case Manager (CM)?
 - CM Name & Telephone Number: _____

Physician Signature: _____	Date: _____
Patient/Caregiver Signature: _____	Date: _____