ENGLISH

My Asthma Plan

Patient Name: ____________________

Medical Record #: ____________________

Physician's Name: ____________________ DOB: ____________________

Physician's Phone #: ____________________ Completed by: ____________________ Date: __________

Controller Medicines	How Much to Take	How Often	Other Instructions
		______ times per day **EVERYDAY!**	
		______ times per day **EVERYDAY!**	
		______ times per day **EVERYDAY!**	
		______ times per day **EVERYDAY!**	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
		Take ONLY as needed	NOTE: If this medicine is needed frequently, call physician to consider increasing controller medications.

Special instructions when I feel *good,* *not good,* and *awful.*

GREEN ZONE

I feel ***good.***

(My **peak flow** is in the **GREEN** zone.)

My Personal Best Peak Flow

PREVENT asthma symptoms everyday:

- ☐ Take my controller medicines (above) everyday.
- ☐ Before exercise, take ______ puffs of ____________
- ☐ Avoid things that make my asthma worse like:

____

YELLOW ZONE

I do ***not*** feel ***good.***

(My **peak flow** is in the **YELLOW** zone.)

80% Personal Best

My symptoms may include one or more of the following:

- Wheeze
- Tight chest
- Cough
- Shortness of breath
- Waking up at night with asthma symptoms
- Decreased ability to do usual activities
- ____________________

____

CAUTION. I should continue taking my everyday controller asthma medicines AND:

- ☐ Take ____________________

____

If I still do not feel good, or my peak flow is not back in the *Green Zone* within one hour, then I should:

- ☐ Increase ____________________

____

- ☐ Add ____________________

____

- ☐ Call ____________________

RED ZONE

I feel ***awful.***

(My **peak flow** is in the **RED** zone.)

50% Personal Best

Warning signs may include one or more of the following:

- Its getting harder and harder to breathe
- Unable to sleep or do usual activities because of trouble breathing

Liters/Min.

Peak Flow Meter

MEDICAL ALERT! Get help!

- ☐ Take ____________________ until I get help immediately.
- ☐ Take ____________________

____

- ☐ Call ____________________

Danger! Get help immediately! **Call 911 if trouble walking or talking due to shortness of breath or lips or fingernails are gray or blue.**

ORIGINAL (Patient) / CANARY (School / Child Care / Work / Other Support Systems) / PINK (Chart)

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SPANISH

Mi Plan de Asma

Nombre del paciente: ______________________

del espediente médico: ______________________

Nombre del doctor: ______________________ Fecha de nacimiento: ______________________

Teléfono: ______________ Realizado por: ______________________ Fecha: ______________

Medicamentos de uso diario	Cuanto Tomar	Cuantas Veces	Otras Instrucciones
		_____ veces al día CADA DIA	
		_____ veces al día CADA DIA	
		_____ veces al día CADA DIA	
		_____ veces al día CADA DIA	

Medicamentos de efecto rápido	Cuanto Tomar	Cuantas Veces	Otras Instrucciones
		Tomar sólo cuando lo necesite	NOTA: si necesita esta medicina frecuentemente, llame a su médico para ver si debe de aumentar el medicamento de uso diario.

Instrucciones especiales cuando me siento ***bien,*** ***mal,*** y ***muy mal.***

ZONA VERDE

Me siento *bien.*

(Mi **flujo de aire máximo** está en la zona **VERDE.**)

Mi flujo de aire máximo

EVITAR: síntomas del asma todos los días

- ☐ Tomar las medicinas indicadas arriba todos los días.
- ☐ Antes de hacer ejercicio tomar _____ inhalaciones __________
- ☐ Evitar cosas que empeoren mi asma tales como: ______________________

ZONA AMARILLA

Me siento *mal.*

(Mi **flujo de aire máximo** está en la zona **AMARILLA.**)

Mis síntomas incluyen uno o más de los siguientes:

- Silbido al respirar
- Sensación de opresión en el pecho
- Tos
- Falta de aliento
- Despertar por la noche con síntomas de asma
- Menos energía para las actividades diarias
- ______________________

80% de mi flujo de aire máximo

PRECAUCIÓN: debo seguir tomando la medicina de uso diario y:

- ☐ Tomar ______________________

Si todavía no me siento bien o mi flujo de aire máximo no está en la *Zona Verde* dentro una hora, entonces debo de:

- ☐ Aumentar ______________________
- ☐ Añadir ______________________
- ☐ Llamar a ______________________

ZONA ROJA

Me siento *muy mal.*

(Mi **flujo de aire máximo** está en la zona **ROJA.**)

Los signos indicativos incluyen uno o más de los siguientes:

- Se me hace más y más difícil respirar
- La falta de respiración no me deja dormir o hacer actividades de costumbre

50% de mi flujo de aire máximo

Liters/Min.

Peak Flow Meter

¡ALERTA! ¡Obtenga ayuda médica!

- ☐ Tomar ______________________ inmediatamente, hasta que reciba ayuda.
- ☐ Tomar ______________________
- ☐ Llamar a ______________________

¡Peligro! ¡Obtenga ayuda de inmediato! Llame al 911, si tiene problemas al caminar o al hablar por la falta de aliento o si sus labios o las uñas están grises o moradas.

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CHINESE

我的哮喘計劃

Patient Name: ____________

Medical Record #: ____________

醫生姓名：____________

DOB: ____________

醫生電話號碼：____________ 填寫人：____________ 日期：____________

控制性藥物	服用量	次數	其它指示
		____ 每日次數 每一天！	
		____ 每日次數 每一天！	
		____ 每日次數 每一天！	
		____ 每日次數 每一天！	
快速紓緩藥物	**服用量**	**次數**	**其它指示**
		只是有需要時才服用	注意：如果需要經常服用這藥物，請打電話給你的醫生要求他/她考慮增加控制性藥物。

當我感到 好 不好 ，及 極壞 時的特別指示

綠區

我感覺好

（我的頂流呼氣計是在綠區）

呼氣頂流計的個人最佳表現

每天**預防**哮喘症狀

☐ 每天服用（上述的）控制性藥物。

☐ 運動前，吸 ____ 口 ____________。

☐ 避免以下可能令哮喘變得更壞的事項：

____

黃區

我感覺不好

（我的頂流呼氣計是在黃區）

我的癥狀可能包括下列其中一項或多項的情況：

- 發出氣喘聲
- 胸口綳緊
- 咳嗽
- 呼吸短促
- 晚上覺醒並出現哮喘症狀
- 日常活動的能力降低
- ____________

____

百份之八十個人的最佳

警告。 我應該繼續每天服用控制性藥物**和**：

☐ 服用 ____________

____

如果我仍然感到不好，或我的呼氣頂流計在一個小時內未能回到綠區，我應該：

☐ 增加 ____________

____

☐ 添加 ____________

____

☐ 致電 ____________

紅區

我感覺極壞

（我的頂流呼氣計是在紅區）

警告跡象可能包括下列其中一項或多項的情況：

- 越來越感到呼吸困難
- 因為呼吸困難而不能入睡或做日常活動

百份之五十個人的最佳

Liters/Min.

Peak Flow Meter

醫療警告！ 現在要尋找幫助！

☐ 服用 ____________ 直至我得到即時的醫療照顧。

☐ 服用 ____________

____

☐ 致電 ____________

危險！ 立刻尋求幫助！

致電911如果由於呼吸短促而出現步行或說話有困難或咀唇或手指甲變灰色或藍色。

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PROVIDER INSTRUCTIONS FOR ASTHMA ACTION PLAN (Adults and Children over 5)

❑ **DETERMINE THE LEVEL OF ASTHMA SEVERITY** (see Table 1)

❑ **FILL IN MEDICATIONS**

Fill in medications appropriate to that level (see Table 1) and include instructions, such as "shake well before using", "use with spacer", and "rinse mouth after using".

❑ **FILL IN PEAK FLOW VALUES AND/OR SYMPTOMS**

Patients over the age of six may be given peak flow meters to monitor their asthma. Fill in the values for the patient's personal best peak flow in the green section (if a personal best has not been established, use a predicted peak flow from outside reference charts). Use 80% of the personal best value in the yellow section, and 50% in the red. See peak flow chart (Table 2) below to help with the calculation. Review symptoms in each zone and write individualized symptoms in blank lines.

❑ **ADDRESS ISSUES RELATED TO ASTHMA SEVERITY**

These can include allergens, smoke, rhinitis, sinusitis, gastroesophageal reflux, sulfite sensitivity, medication interactions, occupational exposures, and viral respiratory infections.

❑ **FILL IN AND REVIEW ACTION STEPS**

Put a check mark in the boxes next to the actions the patient should follow and complete the recommendations. Review the whole plan with the patient/family so they are clear on how to adjust the medications, and when to call for help.

❑ **DISTRIBUTE COPIES OF THE PLAN**

Give the top copy of the plan to the patient, the next to school/day care/work/ caretaker/or other involved third party, and file the last copy in the chart.

❑ **REVIEW ACTION PLAN REGULARY (Step Up / Step Down Therapy)**

A patient who is always in the green zone for some months may be a candidate to "step down" and be reclassified to a lower level of asthma severity and treatment. A patient frequently in the yellow or red zone should be assessed to make sure inhaler technique is correct, compliance is good, environmental factors are not interfering with treatment, and alternative diagnoses have been considered. If these considerations are met, the patient out a new asthma action plan when changes in treatment are made.

TABLE 1: Severity and medication chart (When categorizing, an individual should be assigned to the most severe grade in which any one feature occurs.)

	Mild Intermittent	Mild Persistent	Moderate Persistent	Severe Persistent
Days with Symptoms	≤ 2 / week	>2 / week but <1 / day	Daily	Continuous
Nighttime Symptoms	≤ 2 / month	>2 / month	>1 / week	Frequent
PEF or FEV_1 *	≥80%	≥80%	>60%-<80%	≤60%
PEF Variability	<20%	20-30%	>30%	>30%
Long Term Control Daily Medicines	**No** daily medication needed.	One daily medication: ♦ Inhaled corticosteroid (low dose) OR ♦ Cromolyn OR nedocromil OR ♦ A leukotriene modifier (check age specifications) OR ♦ Sustained-release theophylline (but not preferred therapy)	One to two daily medications: An anti-inflammatory ♦ Inhaled corticosteroid (medium dose) OR, especially if nighttime symptoms: An anti-inflammatory ♦ Inhaled corticosteroid (low, medium, or high dose) AND a long-acting bronchodilator	Three daily medications: An anti-inflammatory ♦ inhaled corticosteroid (high dose) AND a long-acting bronchodilator ♦ long–acting inhaled beta$_2$-agonist OR ♦ sustained-release theophylline OR ♦ long-acting beta$_2$-agonist tablets AND corticosteroid tablets or syrup long term

* Percent predicted values for forced expiratory volume in 1 second (FEV_1) and percent of personal best for peak expiratory flow (PEF) (children 6 years old or older who can use these devices)

TABLE 2: Peak flow value calculation chart (100%, 80%, 50%)

Green - 100%	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290	300	310	320	330	340	350	360	370	380	390
Yellow - 80%	80	88	96	104	112	120	128	136	144	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	280	288	296	304	312
Red - 50%	50	55	60	65	70	75	80	85	90	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195

Green - 100%	400	410	420	430	440	450	460	470	480	490	500	510	520	530	540	550	560	570	580	590	600	610	620	630	640	650	660	670	680	690
Yellow - 80%	320	328	336	344	352	360	368	376	384	392	400	408	416	424	432	440	448	456	464	472	480	488	496	504	512	520	528	536	544	552
Red - 50%	200	205	210	215	220	225	230	235	240	245	250	255	260	265	270	275	280	285	290	295	300	305	310	315	320	325	330	335	340	345

This Asthma Action Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. It is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 97-4051 (April 1997). The information contained herein is intended for the use and convenience of physicians and other medical personnel, and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in the light of available resources and the circumstances presented by individual patients. Neither the Public Health Institute nor the individuals, and institutional participants in the RAMP Initiative make any warranty or guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the form or the Guidelines. For additional information, please contact RAMP at (510) 883-9980, http://www.rampasthma.org

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