

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.)

YELLOW ZONE

I do *not* feel *good*.
(My peak flow is in the **YELLOW** zone.)

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

RED ZONE

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

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

PREVENT asthma symptoms everyday:

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

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 _____

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.

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 should "step up" to a higher classification of asthma severity and treatment. Be sure to fill 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 FEV₁ *	≥80%	≥80%	>60%-<80%	≤60%
PEF Variability	<20%	20-30%	>30%	>30%
Long Term Control Daily Medicines	No daily medication needed.	<i>Preferred treatment: One daily medication • low dose-inhaled corticosteroids Alternative treatment (listed alphabetically): Cromolyn, Leukotriene modifier, Nedocromil, OR sustained release theophylline to serum concentration of 5-15 mcg/ml</i>	<i>Preferred treatment: Two daily medications • Low-to-medium dose inhaled corticosteroids and • Long-acting inhaled beta2-agonists Alternative treatment: Increased inhaled corticosteroids within medium-dose range OR Low-to-medium dose inhaled corticosteroids and either leukotriene modifier or theophylline. If needed (particularly in patients with recurring severe exacerbations): Preferred treatment: Increase inhaled corticosteroids within medium-dose range and add long-acting inhaled beta2-agonists. Alternative treatment: increase inhaled corticosteroids within medium-dose range and add either leukotriene modifier or theophylline.</i>	<i>Preferred treatment: High-dose inhaled corticosteroid AND Long-acting inhaled beta2-agonist AND, if needed, Corticosteroid tablets or syrup long term (2mg/kg/day, generally do not exceed 60 mg/day). (Make repeat attempts to reduce systemic corticosteroids and maintain control with high-dose inhaled corticosteroids.)</i>

* Percent predicted values for forced expiratory volume in 1 second (FEV₁) 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) and ‘Undated Selected Topics 2002,’ NIH Publication No. 02-5075 (June 2002).’ 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) 622-4438,