MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For the use of this form, see AR 40-400: the proponent agency is The Office of the Surgeon General

REPORT TITLE	OTSG APPROVED (DATE) -
ASTHMA ACTION PLAN	15 Dec 99

Personal Best: _____

GREEN - "Good To Go"
Breathing Good, No Cough or Wheeze.
Can work or play,
Sleep through the night.
Add'l Symptoms:

Triggers: _____

Trigger Management: _____

Follow-Up Appt (Date/Time): _____ **With:** _____

Controllers	**Dose**	**Frequency**
Use EVERY day to prevent attacks		

OPTIONAL
>80% personal best
Peak Flow
More Than:

Your quick reliever medicine is: _____

☐ **Take reliever medicine 20 minutes before exercise.**
Remember to use your SPACER with all of your Metered Dose Inhalers

YELLOW - CAUTION
Signs/Symptoms:
Cough, wheeze, chest tightness, Shortness of breath, Wake up at night.
Add'l Symptoms:

Continue GREEN ZONE medications
TAKE RELIEVER MEDICINE 2-6 PUFFS EVERY 20 MINUTES UP TO ONE HOUR
OR nebulizer unit dose every 20 minutes x 3
THEN, recheck symptoms/peak flow:
If still YELLOW

☐ Increase Reliever 2-4 puffs every 4 hours for _____ days
☐ _____
☐ Add _____
Provider Recommendations:

OPTIONAL
50-80% of personal best
Peak Flow:
to

☐ Call health care provider for an appointment. **Phone #:** _____

RED - STOP - DANGER
SIGNS/SYMPTOMS:
Medicine not helping, can't talk or eat/drink well, Lips turn blue or gray

TAKE RELIEVER MEDICINE 4-8 PUFFS EVERY 20 MINUTES X 3
OR NEBULIZER UNIT DOSE EVERY 20 MINUTES X 3
WHILE CALLING 911 OR IN ROUTE TO THE EMERGENCY ROOM
Provider Recommendations:

OPTIONAL
<50% of personal best
Peak Flow
Less Than:

Upon admission to EMERGENCY Department or Inpatient care, Asthma Action plan is placed on hold.

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For a typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☒ OTHER (Specify) Action Plan
☐ DIAGNOSTIC STUDIES
☐ TREATMENT