

Asthma Action Plan



Patient Name: _____ Gateway Number: _____

Doctor: _____ Doctor's Phone: _____



Peak Flow Zone	Action
<p>GREEN ZONE - All Clear Peak Flow: _____ or above * No Symptoms * Able to do usual activities * Usual medications control asthma</p>	<p>Continue with medications as listed in your self care plan.</p>
<p>YELLOW ZONE - Caution Peak Flow: _____ To _____ * Increased asthma symptoms including waking at night, breathing trouble, _____, _____, _____. * Usual activities limited * Increased need for asthma quick-relief medications.</p>	<p><input type="checkbox"/> Take _____ puffs of quick-relief medicine. Repeat _____ times. <input type="checkbox"/> Take _____ puffs of _____ control medication _____ times a day. <input type="checkbox"/> Begin or increase treatment with oral steroids. <input type="checkbox"/> Take _____ every _____. <input type="checkbox"/> Call your doctor _____.</p>
<p>RED ZONE - Danger!! Peak Flow: Less than _____ * Increased symptoms for longer than 24 hours * Very short of breath * Usual activities are severely limited * Asthma medications have not reduced symptoms</p>	<p style="text-align: center;">EMERGENCY!!</p> <p><input type="checkbox"/> Take _____ puffs of quick-relief medicine. Repeat _____ times. <input type="checkbox"/> Begin or increase treatment with oral steroids. Take _____ every _____. <input type="checkbox"/> Call your doctor, but do not wait for a call back. <input type="checkbox"/> Go to the Emergency Room now!</p>

DANGER!! Fingernails or lips are blue *or* difficulty walking or talking due to shortness of breath
GO TO THE EMERGENCY ROOM NOW!!

Patient's Signature _____ Date: _____ RT Signature _____ Date: _____

Doctor's Signature _____ Date: _____ Next Doctor visit for re-check _____

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