Santé et Services sociaux Québec

DT9256

Action Plan for Asthma

File _____

Name _____

Address _____

_____

Date of birth _____

Quiz

IN THE LAST 7 DAYS, did I cough, wheeze or have a hard time breathing...

1) During daytime, **4 days or more**? YES NO
2) Enough to wake up at night, **1 or more times**? YES NO
3) Enough to use my BLUE pump (RELIEF medication) **4 or more times**, including 1 time per day before exercise? YES NO
4) Enough to limit me in my **physical activity**? YES NO
5) Enough to **miss** regular activities, school or work? YES NO

How many times did I answer YES? _____

If none (**0**): asthma under control ● If **1** or more: asthma not well ctrolled ◆

PRESCRIPTION Date: _____

● Asthma under control — What to do? — Take my maintenance medication:

- ○ **I answered YES to none (0) of the questions on the Asthma Quiz** AND
- ○ I feel good AND
- ○ If I use a peak flow meter, my readings are normal (_____ or more)

5 tips to stay under control: See on back

○ CONTROL medication _____ µg/puff # ____

_____ (colour) ____ puff(s) ____ times/day **every day** R ____

○ OTHER(S) _____

_____

○ RELIEF medication **blue**: _____ µg/puff # ____

____ puff(s) **as needed** (less than 4 times/week) or **before exercise** (max.: 1 time/day) R ____

○ Holding Chamber _____

_____

◆ Asthma not well controlled — What to do? — Adjust my treatment: (and tell an adult, if I am a child)

- ◇ **I answered YES to 1 or more questions on the Asthma Quiz** OR
- ◇ I cough, wheeze or have difficulty breathing OR
- ◇ I start a cold OR
- ◇ My peak flow readings have dropped (between _____ and _____)

◇ CONTROL medication _____ µg/puff # ____

_____ (colour) ____ puff(s) ____ times/day _____ (duration of treatment) R ____

◇ OTHER(S) _____

_____

◇ RELIEF medication **blue**: ____ puff(s) **as needed** (do not repeat before ____ hours)

If: _____ (criteria of inadequate response), I have to:

_____ (additional medication, consultation, etc.)

I have finished my adjusted treatment and I feel better: I go to the ● section

I feel worse: I go to the ■ section

Physician _____ (Print letters) _____

Dr _____ (Signature) _____ (License number)

■ Asthma out of control — What to do? It is URGENT:

- ☐ My cough, wheeze, or breathing is getting **worse** OR
- ☐ My BLUE pump (RELIEF medication) **helps me** for **less than 4 hours** OR
- ☐ My peak flow readings have dropped (less than _____)

I have to call or see a doctor right away.

AH-708A DT9256 (rev. 2014-03)

PHARMACIST ORIGINAL

Partie 1 – RECTO avec code barre DT9256 en Noir et Pantone 131, 1795 et 3405

Santé et Services sociaux Québec

DT9256

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File _____

Name _____

Address _____

_____

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AH-708A DT9256 (rev. 2014-03)

MEDICAL CHART COPY

Santé et Services sociaux Québec

DT9256

File _____

Name _____

Address _____

_____

Date of birth _____

Action Plan for Asthma

Quiz

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AH-708A DT9256 (rev. 2014-03)

USER COPY

Partie 3 – RECTO avec code barre DT9256 en Noir et Pantone 131, 1795 et 3405

Action Plan for Asthma

EVERYONE WITH ASTHMA

CAN LEAD AN ACTIVE LIFE!

Asthma is a disease that affects my lungs (bronchi) EVERY DAY, even between asthma attacks.
I can control my asthma if I take care of it EVERYDAY, even when I feel good.

My Action Plan will help me:
- **Keep my asthma under control everyday.**
- **Prevent an asthma attack.**

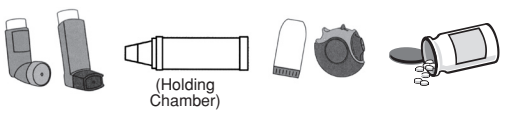
5 TIPS TO STAY UNDER CONTROL

1 Avoid what triggers my asthma.

1 866 j'arrête
1 866 527-7383
www.jarrete.qc.ca

- I must avoid smoking or being in a house or a car where someone smokes.
- I agree to: _____ .
  (avoid… get rid of… get…)
- When I am exposed to _____ , I have to take _____ .
- If I get a cold, I will use my Action Plan, blow my nose and, if needed, clean it with saline water _____ ____ times a day.

2 Take my maintenance medication (green section).



- I review the way I use my pumps (inhalers) with my ***pharmacist*** or my ***asthma educator***.
- My **tricks** to remember to take my medication are: _____
  _____

3 Retake the Asthma *Quiz* regularly.

4 See my *doctor* regularly.

- My ***doctor*** _____ (_____
  will review with me my Action Plan in: _____
  (when)

5 Get some help.

- Health professionals are there to help me use my Action Plan:
  – My ***pharmacist*** _____ (_____
  – My ***asthma educator**** _____ (_____
  * Réseau québécois de l'asthme et de la MPOC (RQAM). www.rqam.ca
  (Quebec Asthma and COPD Network) (1 877 441-5072

MY PERSONAL OBJECTIVES

My Action Plan will help me to:
I draw or set my own goal *(optional)*