

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 controlled ◆

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 _____ $\mu\text{g/puff}$ # _____
_____ puff(s) _____ times/day **every day** R _____
(colour)

OTHER(S) _____

RELIEF medication **blue**: _____ $\mu\text{g/puff}$ # _____
_____ 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 _____)

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

I feel worse: I go to the ■ section

CONTROL medication _____ $\mu\text{g/puff}$ # _____
_____ puff(s) _____ times/day _____ (duration of treatment) R _____
(colour)

OTHER(S) _____

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

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

(additional medication, consultation, etc.)

Physician _____ Print letters _____ ☎ _____

D: _____ Signature _____ License number _____

Asthma out of control

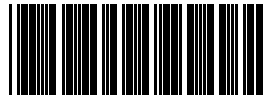
What to do? It is URGENT:

My cough, wheeze, or breathing is getting **worse** **OR**

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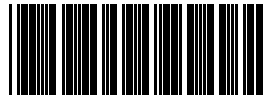
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Action Plan for Asthma

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

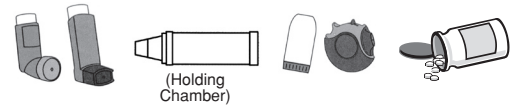
1 Avoid what triggers my asthma.



☎ 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*)