

DT9256



## Action Plan for Asthma

### Quiz

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

- |  |     |    |
|--|-----|----|
| 1) During daytime, <b>4 days or more</b> ?   | YES | NO |
| 2) Enough to wake up at night, <b>1 or more times</b> ?  | YES | NO |
| 3) Enough to use my BLUE pump (RELIEF medication) <b>4 or more times</b> , including 1 time per day before exercise? | YES | NO |
| 4) Enough to limit me in my <b>physical activity</b> ?   | YES | NO |
| 5) Enough to <b>miss</b> 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 ◆

File \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_

**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 \_\_\_\_\_ R \_\_\_\_\_  
(colour) (duration of treatment)

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

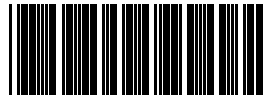
### What to do? It is URGENT:

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

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.**



DT9256



## Action Plan for Asthma

### Quiz

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

- |  |     |    |
|--|-----|----|
| 1) During daytime, <b>4 days or more</b> ?   | YES | NO |
| 2) Enough to wake up at night, <b>1 or more times</b> ?  | YES | NO |
| 3) Enough to use my BLUE pump (RELIEF medication) <b>4 or more times</b> , including 1 time per day before exercise? | YES | NO |
| 4) Enough to limit me in my <b>physical activity</b> ?   | YES | NO |
| 5) Enough to <b>miss</b> 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 cttrolled ◆

File \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_

**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 \_\_\_\_\_ R \_\_\_\_\_  
(colour) (duration of treatment)

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

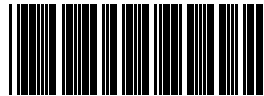
### What to do? It is URGENT:

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

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.***



DT9256



## Action Plan for Asthma

### Quiz

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

- |  |     |    |
|--|-----|----|
| 1) During daytime, <b>4 days or more</b> ?   | YES | NO |
| 2) Enough to wake up at night, <b>1 or more times</b> ?  | YES | NO |
| 3) Enough to use my BLUE pump (RELIEF medication) <b>4 or more times</b> , including 1 time per day before exercise? | YES | NO |
| 4) Enough to limit me in my <b>physical activity</b> ?   | YES | NO |
| 5) Enough to <b>miss</b> 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 ◆

File \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Date of birth \_\_\_\_\_

**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 \_\_\_\_\_ R \_\_\_\_\_  
(colour) (duration of treatment)

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

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.***



## 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

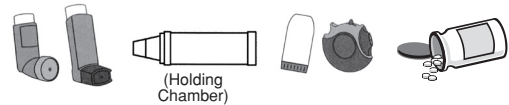
#### 1 Avoid what triggers my asthma.



☎ 1 866 j'arrête  
☎ 1 866 527-7383  
[www.jarrete.qc.ca](http://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](http://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*)