

## PROVIDER INSTRUCTIONS

### At initial presentation, determine the level of asthma severity

- Level of severity is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.



### At subsequent visits, assess control to adjust therapy

- Level of control is determined by both impairment and risk and is assigned to the most severe category in which any feature occurs.
- Address adherence to medication, inhaler technique, and environmental control measures.
- Sample patient self-assessment tools for asthma control can be found at <http://www.asthmacontrol.com/index.html> <http://www.asthmacontrolcheck.com>



### Stepwise approach for managing asthma:

- Therapy is increased (stepped up) if necessary and decreased (stepped down) when possible as determined by the level of asthma severity or asthma control.

**Asthma severity and asthma control include the domains of current impairment and future risk.**

**Impairment:** frequency and intensity of symptoms and functional limitations the patient is currently experiencing or has recently experienced.

**Risk:** the likelihood of either asthma exacerbations, progressive decline in lung function (or, for children, reduced lung growth), or risk of adverse effects from medication.

## ASTHMA MANAGEMENT RECOMMENDATIONS:

- Ensure that patient/family receive education about asthma and how to use spacers and other medication delivery devices.
- Assess asthma control at every visit by self-administered standardized test or verbal history.
- Perform spirometry at baseline and at least every 1 to 2 years for patients  $\geq 5$  years of age.
- Update or review the Asthma Action Plan every 6 to 12 months.
- Perform skin or blood allergy tests for all patients with persistent asthma.
- Encourage patient/family to continue follow-up with their clinician every 1 to 6 months even if asthma is well controlled.
- Refer patient to a specialist if:
  - there are difficulties achieving or maintaining control OR
  - step 4 care or higher is required (step 3 care or higher for children 0-4 years of age) OR
  - immunotherapy or omalizumab is considered OR
  - additional testing is indicated OR
  - if the patient required 2 bursts of oral systemic corticosteroids in the past year or a hospitalization.

## HOW TO USE THE ASTHMA ACTION PLAN:

### Top copy (for chart):

- **File this copy in the patient's medical chart.**

### Middle copy (for patient):

- Enter specific medication information and review the instructions with the patient and/or family.
- Educate patient and/or family about factors that make asthma worse and the remediation steps on the back of this form.
- **Complete and sign the bottom of the form and give this copy of the form to the patient.**

### Bottom copy (for school, childcare, work, etc):

- Educate the parent/guardian on the need for their signature on the back of the form in order to authorize student self-carry and self-administration of asthma medications at school and also to authorize sharing student health information with school staff.
- **Provide this copy of the form to the school/childcare center/work/caretaker or other involved third party. (This copy may also be faxed to the school, etc.)**

## FOR MORE INFORMATION:

To access the August 2007 full version of the NHLBI Guidelines for the Diagnosis and Treatment of Asthma (EPR-3) or the October 2007 Summary Report, visit <http://www.nhlbi.nih.gov/guidelines/asthma/index.htm>.

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# My Asthma Plan

ENGLISH

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Provider's Phone #: \_\_\_\_\_ Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day <b>EVERY DAY!</b>	<input type="checkbox"/> Gargle or rinse mouth after use
		_____ times per day <b>EVERY DAY!</b>	
		_____ times per day <b>EVERY DAY!</b>	
		_____ times per day <b>EVERY DAY!</b>	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
<input type="checkbox"/> Albuterol (ProAir, Ventolin, Proventil) <input type="checkbox"/> Levalbuterol (Xopenex)	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 nebulizer treatment	Take <b>ONLY</b> as needed (see below — starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medications and discuss your treatment plan.


Special instructions when I am  *doing well*,  *getting worse*,  *having a medical alert*.

**Doing *well*.**

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

**Peak Flow** (for ages 5 and up):  
is \_\_\_\_\_ or more. (80% or more of personal best)

**Personal Best Peak Flow** (for ages 5 and up): \_\_\_\_\_




**PREVENT** asthma symptoms every day:

- ☐ Take my controller medicines (above) every day.
- ☐ Before exercise, take \_\_\_\_\_ puff(s) of \_\_\_\_\_
- ☐ Avoid things that make my asthma worse. (See back of form.)

**Getting *worse*.**

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

**Peak Flow** (for ages 5 and up):  
\_\_\_\_\_ to \_\_\_\_\_ (50 to 79% of personal best)




**CAUTION.** Continue taking every day controller medicines, AND:

- ☐ Take \_\_\_\_\_ puffs or \_\_\_\_\_ one nebulizer treatment of quick relief medicine. If I am not back in the **Green Zone** within 20-30 minutes take \_\_\_\_\_ more puffs or nebulizer treatments. If I am not back in the **Green Zone** within one hour, then I should:
- ☐ Increase \_\_\_\_\_
- ☐ Add \_\_\_\_\_
- ☐ Call \_\_\_\_\_
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in \_\_\_\_\_ days.

**Medical Alert**

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

**Peak Flow** (for ages 5 and up):  
less than \_\_\_\_\_ (50% of personal best)



**MEDICAL ALERT! Get help!**

- ☐ Take quick relief medicine: \_\_\_\_\_ puffs every \_\_\_\_\_ minutes and get help immediately.
- ☐ Take \_\_\_\_\_
- ☐ Call \_\_\_\_\_

**Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.**

**Health Care Provider:** My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ☐ Yes ☐ No self administer asthma medications: ☐ Yes ☐ No (This authorization is for a maximum of one year from signature date.)

Healthcare Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

ORIGINAL (Patient) / CANARY (School/Child Care/Work/Other Support Systems) / PINK (Chart)

This Asthma Plan was developed by a committee facilitated by the Regional Asthma Management and Prevention (RAMP) Initiative, a program of the Public Health Institute. This publication was supported by Cooperative Agreement Number 1U58DP001016-01 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC. This plan is based on the recommendations from the National Heart, Lung, and Blood Institute's, "Guidelines for the Diagnosis and Management of Asthma," NIH Publication No. 07-4051 (August 2007). The information contained herein is intended for the use and convenience of physicians and other medical personnel and may not be appropriate for use in all circumstances. Decisions to adopt any particular recommendation must be made by qualified medical personnel in light of available resources and the circumstances presented by individual patients. No entity or individual involved in the funding or development of this plan makes any warranty or guarantee, express or implied, of the quality, fitness, performance or results of use of the information or products described in the plan or the Guidelines.

For additional information, please contact  
**RAMP at (510) 302-3365, <http://www.rampasthma.org>.**

# 我的氣喘護理計畫 CHINESE

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

醫務人員姓名: \_\_\_\_\_ DOB: \_\_\_\_\_

醫務人員電話號碼: \_\_\_\_\_ 填寫人: \_\_\_\_\_ 日期: \_\_\_\_\_

控制藥物	服用數量	服用次數	其他說明
		_____ 次/每天 每天服用！	<input type="checkbox"/> 服藥後漱口
		_____ 次/每天 每天服用！	
		_____ 次/每天 每天服用！	
		_____ 次/每天 每天服用！	
快速舒緩藥物	服用數量	服用次數	其他說明
<input type="checkbox"/> Albuterol (ProAir、Ventolin、Proventil) <input type="checkbox"/> Levalbuterol (Xopenex)	<input type="checkbox"/> 吸藥兩次 <input type="checkbox"/> 吸藥四次 <input type="checkbox"/> 1 次噴霧器治療	需要時才服用 (請參閱以下指示 — 於黃區開始時， 或運動前使用)	注意：如果您每週需要服用本藥物兩天以上，請電洽醫師，考慮增加控制藥物的服用劑量，並討論您的治療計畫。

右列情況下的特殊指示： ● 病情穩定 ● 病情惡化 ● 病情緊急

## 病情穩定。

- 日間或夜間無咳嗽、喘鳴聲、胸悶或呼吸急速情況發生。
- 可從事正常活動

尖峰呼氣流速 (適用於 5 歲以上)：  
為 \_\_\_\_\_ 以上。(個人最佳紀錄的 80% 以上)

個人最佳尖峰呼氣流速 (適用於 5 歲以上)：\_\_\_\_\_



下列的每日例行工作可**避免**氣喘症狀發作：

- ☐ 每天服用上述控制藥物。
- ☐ 運動前，吸入 \_\_\_\_\_ 次數 \_\_\_\_\_
- ☐ 避免會讓我氣喘症狀惡化的情況。  
(請見表格背面。)

## 病情惡化。

- 咳嗽、喘鳴聲、胸悶、呼吸急速，或
- 因氣喘發作而在夜間醒來，或
- 可從事一些 (但並非全部) 正常活動

尖峰呼氣流速 (適用於 5 歲以上)：  
\_\_\_\_\_ 至 \_\_\_\_\_ (個人最佳紀錄的 50 至 79%)



**警戒範圍。**每天持續服用控制藥物，並：

- ☐ 吸入 \_\_\_\_\_ 次數快速舒緩藥物或進行 \_\_\_\_\_ 次噴霧器治療。如果我在 20-30 分鐘內未回到綠區，必須再多吸藥 \_\_\_\_\_ 次或進行 \_\_\_\_\_ 次噴霧器治療。如果我在 1 小時內未回到綠區，我應該：
- ☐ 增加 \_\_\_\_\_
- ☐ 新增 \_\_\_\_\_
- ☐ 致電 \_\_\_\_\_
- ☐ 視需要每 4 小時服用快速舒緩藥物。如果 \_\_\_\_\_ 天後仍無改善，請電洽服務提供者。

## 病情緊急

- 呼吸非常急速，或
  - 快速舒緩藥物無效，或
  - 無法從事正常活動，或
  - 症狀處於黃區 24 小時後仍無改善或惡化。
- 尖峰呼氣流速 (適用於 5 歲以上)：  
少於 \_\_\_\_\_ (個人最佳紀錄的 50%)



**病情緊急！就醫治療！**

- ☐ 服用快速舒緩藥物：每 \_\_\_\_\_ 分鐘吸入 \_\_\_\_\_ 次數，並即刻送醫。
- ☐ 服用 \_\_\_\_\_
- ☐ 致電 \_\_\_\_\_

**危險！盡速就醫！**如因呼吸急速而難以步行或說話，或有嘴唇或指甲發灰或發藍現象，請撥 911 求救。  
病患者如為兒童，呼吸時，如頸周圍的皮膚和肋骨縮緊下陷，或病患者無法正常回應，請撥 911 求救。

**Health Care Provider:** My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ☐ Yes ☐ No self administer asthma medications: ☐ Yes ☐ No  
(This authorization is for a maximum of one year from signature date.)

Healthcare Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

ORIGINAL (Patient) / CANARY (School/Child Care/Work/Other Support Systems) / PINK (Chart)

# 控管下列使氣喘症狀惡化的因子

## ❑ 吸菸

- 請勿吸菸。參加戒菸療程。
- 嚴禁在家中或車內吸菸。即使是殘存的菸味都有可能使氣喘發作。
- 遠離吸菸者。
- 如果您有吸菸的習慣，請在戶外吸菸。



## ❑ 灰塵

- 每週使用附高效濾網的吸塵器或中央吸塵器吸地。吸地時儘可能不要讓患有氣喘的家人待在家裡。
- 儘可能移除地毯。拆下地毯前先將地毯打濕，然後再將地板完全擦乾。
- 每週用濕抹布拖地。
- 每 1-2 週清洗床單和布玩具。不能水洗的布玩具，請將其置於冷凍庫內 24 小時。
- 用防塵蹣的拉鍊枕頭套和床單包覆床墊與枕頭。
- 減少環境的凌亂與雜物堆放，且勿擺放動物布玩具，尤其不要在床邊擺放布玩具。
- 定期更換暖氣濾網。



## ❑ 害蟲

- 食物或垃圾勿散置在外。將食物存放在密閉容器內。
- 試著使用捕蟲裝置和毒餌誘殺害蟲，例如使用硼酸來毒殺蟑螂。勿使用噴劑/霧劑，將毒餌放在兒童拿不到的地方，例如冰箱後面。
- 用吸塵器將蟑螂屍體殘骸吸淨，用塑膠料或銅絲填隙縫。
- 修補滲漏的水管、屋頂及其他會漏水的地方。



## ❑ 黴菌

- 淋浴或下廚時，使用抽風機或打開窗戶，使空氣對流。
- 將洗潔精倒入熱水中，使用硬刷子或清洗用的菜瓜布刮除堅硬物品表面的黴菌，然後再以水洗淨。能吸附黴菌的材質必須加以更換。
- 清掃工作進行時，請勿讓氣喘病患留在屋內。
- 修補滲漏的水管或其他會漏水或散發溼氣的物品。



## ❑ 動物

- 考慮不要飼養寵物。勿靠近有皮毛的寵物。
- 勿讓寵物進入氣喘患者的臥房。
- 您本身以及氣喘患者都必須在觸摸動物後洗手。



## ❑ 異味/噴霧

- 請勿使用味道強烈的用品，例如居家除臭劑和薰香，以及衣物芳香洗劑及個人保養品。
- 勿使用烤箱暖屋。
- 打掃時，請勿讓氣喘患者留在屋內，且不要使用味道強烈的清潔用品。
- 避免使用噴霧劑。
- 避免使用強力或強效的清潔用品。
- 避免使用氨水、漂白水 and 消毒水。



## ❑ 花粉與戶外黴菌

- 當戶外花粉濃度高、黴菌數量多時，請盡量待在室內。
- 授粉季節請關上家中窗戶。
- 避免使用電風扇；改用空調。

## ❑ 感冒/流感

- 以充分運動、充足睡眠的生活習慣保持身體健康。
- 避免與感冒患者近距離接觸。
- 經常洗手，避免用手摸臉。
- 每年接種流感疫苗。



## ❑ 天氣變化與空氣污染

- 如果冷空氣使您不適，試著用圍巾掩鼻子呼吸，不要張口呼吸。
- 查詢清潔空氣日 (Spare the Air days) 的白天與夜間時段，避免在這些時段到戶外從事激烈運動。
- 在戶外空氣污染非常嚴重時，待在室內，關上窗戶。

## ❑ 運動

- 運動前請暖身。
- 規劃戶外花粉濃度高或空氣污染嚴重時，可以在室內進行的替代運動。
- 遵照醫師指示，必要時在運動前服藥。(請參閱「氣喘護理計畫」的綠區。)

# My Asthma Plan

ENGLISH

Patient Name: \_\_\_\_\_

Medical Record #: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Provider's Phone #: \_\_\_\_\_ Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Controller Medicines	How Much to Take	How Often	Other Instructions
		_____ times per day <b>EVERY DAY!</b>	<input type="checkbox"/> Gargle or rinse mouth after use
		_____ times per day <b>EVERY DAY!</b>	
		_____ times per day <b>EVERY DAY!</b>	
		_____ times per day <b>EVERY DAY!</b>	

Quick-Relief Medicines	How Much to Take	How Often	Other Instructions
<input type="checkbox"/> Albuterol (ProAir, Ventolin, Proventil) <input type="checkbox"/> Levalbuterol (Xopenex)	<input type="checkbox"/> 2 puffs <input type="checkbox"/> 4 puffs <input type="checkbox"/> 1 nebulizer treatment	Take <b>ONLY</b> as needed (see below — starting in Yellow Zone or before exercise)	NOTE: If you need this medicine more than two days a week, call physician to consider increasing controller medica- tions and discuss your treatment plan.

Special instructions when I am  *doing well*,  *getting worse*,  *having a medical alert*.

## Doing *well*.

- No cough, wheeze, chest tightness, or shortness of breath during the day or night.
- Can do usual activities.

**Peak Flow** (for ages 5 and up):  
is \_\_\_\_\_ or more. (80% or more of personal best)

**Personal Best Peak Flow** (for ages 5 and up): \_\_\_\_\_



**PREVENT** asthma symptoms every day:

- ☐ Take my controller medicines (above) every day.
- ☐ Before exercise, take \_\_\_\_\_ puff(s) of \_\_\_\_\_
- ☐ Avoid things that make my asthma worse.  
(See back of form.)

GREEN ZONE

## Getting *worse*.

- Cough, wheeze, chest tightness, shortness of breath, or
- Waking at night due to asthma symptoms, or
- Can do some, but not all, usual activities.

**Peak Flow** (for ages 5 and up):  
\_\_\_\_\_ to \_\_\_\_\_ (50 to 79% of personal best)



**CAUTION.** Continue taking every day controller medicines, AND:

- ☐ Take \_\_\_\_\_ puffs or \_\_\_\_\_ one nebulizer treatment of quick relief medicine. If I am not back in the **Green Zone** within 20-30 minutes take \_\_\_\_\_ more puffs or nebulizer treatments. If I am not back in the **Green Zone** within one hour, then I should:
- ☐ Increase \_\_\_\_\_
- ☐ Add \_\_\_\_\_
- ☐ Call \_\_\_\_\_
- ☐ Continue using quick relief medicine every 4 hours as needed. Call provider if not improving in \_\_\_\_\_ days.

YELLOW ZONE

## Medical Alert

- Very short of breath, or
- Quick-relief medicines have not helped, or
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone.

**Peak Flow** (for ages 5 and up):  
less than \_\_\_\_\_ (50% of personal best)



**MEDICAL ALERT! Get help!**

- ☐ Take quick relief medicine: \_\_\_\_\_ puffs every \_\_\_\_\_ minutes and get help immediately.
- ☐ Take \_\_\_\_\_
- ☐ Call \_\_\_\_\_

RED ZONE

**Danger! Get help immediately! Call 911 if trouble walking or talking due to shortness of breath or if lips or fingernails are gray or blue. For child, call 911 if skin is sucked in around neck and ribs during breaths or child doesn't respond normally.**

**Health Care Provider:** My signature provides authorization for the above written orders. I understand that all procedures will be implemented in accordance with state laws and regulations. Student may self carry asthma medications: ☐ Yes ☐ No self administer asthma medications: ☐ Yes ☐ No (This authorization is for a maximum of one year from signature date.)

Healthcare Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

ORIGINAL (Patient) / CANARY (School/Child Care/Work/Other Support Systems) / PINK (Chart)



## CHINESE

☐ 是 ☐ 否

日期

## 區碼與電話號碼