

Patient Name Label

# Maine Asthma Action/Management Plan

Personal best or predicted Peak Flow \_\_\_\_\_

Current Medications	How Much	How Often Each Day
<b>Preventive/Controller Medicines</b>		
<b>Quick Relief Medicines</b>		
<b>Other Instructions:</b>		

**Remember to get your Flu shot each year!**

**Goals:** ❖ No severe symptoms    ❖ Can do activities of your choice    ❖ No work or school missed due to asthma    ❖ Best possible lung function  
 ❖ No emergency visits or hospitalizations for asthma    ❖ Lowest dose of medicines that control asthma with fewest side effects

**YOUR GOALS:** \_\_\_\_\_

**Green Zone**  
**Doing Great!**  
**Peak Flow**  
**80-100%**

**Yellow Zone**  
**Caution!**  
**Asthma is getting worse**  
**Peak Flow**  
**50-80%**

**Red Zone**

Peak Flow = \_\_\_\_\_ - \_\_\_\_\_

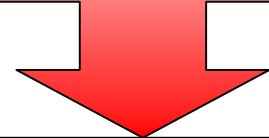
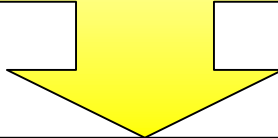
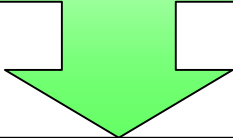
Peak Flow = \_\_\_\_\_ - \_\_\_\_\_

Peak Flow less than \_\_\_\_\_

- No cough, wheeze, or difficulty breathing
- Sleep through the night
- Can do usual activities
- Peak flow 80-100% of personal best

- Cough, wheeze, short of breath, or using quick relief medicine more than two extra times per week
- Waking at night due to cough or wheeze more than 2 times a month
- Can't do regular activities
- Peak flow 50-80% of personal best

- Very short of breath
- Hard time walking or talking
- Skin in neck or between ribs pulls in
- Quick relief medicines not helping
- Peak flow less than 50% personal best



- Take your regular preventive medicines
- Exercise regularly
- Avoid your triggers:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- Begin using quick relief nebulizer or quick relief inhaler every 4-6 hours  
 Quick relief medicine: \_\_\_\_\_
  - Other: \_\_\_\_\_
- If your quick relief medicine isn't working or you are not getting better in 24-48 hours, please call your healthcare provider!

- Take a nebulizer treatment, or 4 puffs of quick relief medicine **NOW**
  - Call your healthcare provider **NOW** or go to the Emergency Room
- OR
- Call 911

Other instructions: \_\_\_\_\_

\_\_\_\_\_

Questions or problems? Please call us at tel. \_\_\_\_\_

\_\_\_\_\_  
 Provider Signature / Clinician Signature

\_\_\_\_\_  
 Date