

GP SERVICES COMMITTEE
CHRONIC DISEASE MANAGEMENT INCENTIVES

Revised
January 2012



Society of
General
Practitioners

Chronic Disease Management (CDM) Payments

The program payments recognize the additional work, beyond the office visit, of providing guideline informed care to patients over a year. The goal is to improve provision of clinically appropriate patient care that considers both the patient's values and the impact of co-morbidities. Effective January 1, 2009, there must be at least 2 visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

They are payable in recognition of work that has been done and are not payable in advance – in other words, they are to be billed after provision of one year of care. Currently, there are CDM annual payments for four conditions: Diabetes, Congestive Heart Failure, Hypertension and Chronic Obstructive Pulmonary Disease.

Effective January 1, 2012 the GPSC has streamlined the initial 4 telephone/e-mail follow up management fees into a single fee billable up to 5 times in the 18 months following the successful billing of one (or more) of the following incentives: 14053 (COPD CDM); 14033 (Complex Care Planning); 14043 (Mental Health Planning); or 14063 (Palliative Planning).

Eligibility:

These payments are available to:

All general practitioners who have a valid BC Medical Service Plan practitioner number (registered specialty 00), except those who have billed any specialty consultation fee in the previous 12 months; and:

- Whose majority professional activity is in full service family practice as described in the introduction, and
- Who has provided the majority of the patient's longitudinal general practice care over the preceding year, and
- Has provided a clinically appropriate level of guideline-informed care.

G14050 GP Annual Chronic Care Bonus – Diabetes Mellitus

Notes:

- General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- Payable to the family physician who has provided the majority of the patient's longitudinal general practice care and a clinically appropriate level of guideline--informed care for diabetes in the preceding year.***
- Applicable only for patients with confirmed diagnosis of diabetes mellitus.*
- This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- Claim must include the ICD-9 code for diabetes (250).*
- This item may only be claimed once per patient in a consecutive 12 month period.*
- Payable when other CDM items G14051 or G14053 have been paid on the same patient.*
- If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14051 GP Annual Chronic Care Bonus – Congestive Heart Failure

Notes:

- General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- Payable to the general practice full service family physician who has provided the majority of the patient's longitudinal general practice care and a clinically appropriate level of guideline--informed care for congestive heart failure in the preceding year.***

- iii) *Applicable only for patients with confirmed diagnosis of congestive heart failure.*
- iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- v) *Claim must include the ICD-9 code for congestive heart failure (428).*
- vi) *This item may only be claimed once per patient in a consecutive 12 month period.*
- vii) *Payable when other CDM items G14050 or G14053 have been paid on the same patient.*
- viii) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14052 GP Annual Chronic Care Bonus – Hypertension

Notes:

- i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) ***Payable to the general practice full service family physician who has provided the majority of the patient’s longitudinal general practice care and a clinically appropriate level of guideline--informed care over the preceding year.***
- iii) *Applicable only for patients with confirmed diagnosis of hypertension.*
- iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- v) ***The patient must be given a copy of the Hypertension flow sheet in order to facilitate patient self-management.***
- vi) *Claim must include the ICD-9 code for hypertension (401).*
- vii) *This item may only be claimed once per patient in a consecutive 12 month period.*
- viii) *Not payable if G14050 or G14051 claimed within the previous 12 months.*
- ix) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

G14053 GP Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease- COPD

Notes:

- i) *General Practitioners who have a valid MSP practitioner number (registered specialty 00) are eligible to bill. Physicians who have billed a specialty consultation fee within the preceding 12 months are not eligible.*
- ii) ***Payable to the general practice full service family physician who has provided the majority of the patient’s longitudinal general practice care and provided a clinically appropriate level of guideline-informed care.***
- iii) *Applicable only for patients with confirmed diagnosis of COPD.*
- iv) ***This item may only be billed after one year of care has been provided and the patient has been seen at least twice in the preceding 12 months.***
- v) ***The patient must be given a copy of their personalized COPD care plan in order to facilitate patient self-management.***
- vi) *Claim must include the ICD-9 code for chronic bronchitis (491), emphysema (492), bronchiectasis (494) or chronic airways obstruction-not elsewhere classified (496).*
- vii) *This item may only be claimed once per patient in a consecutive 12 month period.*
- viii) *Payable when other CDM items G14050, G14051 or G14052 have been paid on the same patient.*
- ix) *If a visit is provided on the same date the bonus is billed; both services will be paid at the full fee.*

Successful billing of the Annual Chronic Care Bonus for COPD (G14053) allows access to 5 Telephone/E-mail follow-up fees (G14079) per calendar year over the following 18 months.

FLOW SHEETS & ACTION PLANS

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year. Chronic Care flow sheets are a useful tool for tracking care provided to patients over time. The GPSC requires physicians to track and document adequately the care provided to their patients to ensure they are providing guideline informed care. While it is not mandatory to utilize official GPAC flow sheets, if you use a different flow sheet, all essential elements from the GPAC guideline must be included. There are other requirements that are incentive specific as outlined below:

- ***Diabetes Patient Care Flow Sheet***
Fee item 14050 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, the patient may find it helpful for self-management.
- ***Congestive Heart Failure Care Flow Sheet***
Fee item 14051 may be billed after the patient has been provided guideline informed care for one year. Although you are not required to give the patient a copy of the flow sheet, the patient may find it helpful for self-management.
- ***Hypertension Care Flow Sheet***
Fee item 14052 may be billed after the patient has been provided guideline informed care for one year. To assist in patient self-management the patient ***must*** be given a copy of their flow sheet for the year.
- ***COPD Patient Action Plan***
Fee item 14053 may be billed after the patient has been provided guideline informed care for one year. There is no flow sheet for the 14053, however, to facilitate self-management, the patient must be provided with their COPD Action plan, jointly developed with their GP, and reviewed and updated regularly.

FREQUENTLY ASKED QUESTIONS

1. How do I claim the condition-based payments?

The incentive payments are payable if the patient has a confirmed diagnosis of diabetes mellitus (*please note this incentive payment is not payable for pre diabetes patients*), congestive heart failure, hypertension or chronic obstructive pulmonary disease. Only one payment per diagnosis is payable per patient per year. The bonus 14052 (hypertension) is not payable if a bonus payment 14050 (diabetes mellitus) or 14051 (congestive heart failure) has been paid for the patient in the preceding year. 14052 (hypertension) is payable in addition to 14053 for those patients who also have COPD.

Condition-based bonus claims are submitted through the MSP Claims system the same way you would submit a MSP fee-for service claim. The submission must include the relevant ICD 9 codes:

Congestive heart failure - 428;
Diabetes mellitus – 250;
Hypertension – 401;
COPD – 491 or 492 or 494 or 496.

2. Is it possible to claim all Chronic Disease Management fees in the same patient?

If a patient has any of the three conditions diabetes mellitus, congestive heart failure, and/or COPD and criteria are met for each condition, each annual incentive bonuses may be billed separately. If a patient has hypertension, the 14052 cannot be billed in addition to Diabetes or CHF, as management of hypertension is included in the guideline for these 2 conditions. If the patient has hypertension and COPD without diabetes or CHF, then both the 14052 and 14053 may be billed on the same patient if all criteria are met.

CDM Allowable Combinations in Single Patient

	14050	14051	14052	14053
14050		Yes	No	Yes
14051	Yes		No	Yes
14052	No	No		Yes
14053	Yes	Yes	Yes	

3. When should the incentive bonus be billed?

All the GPSC Chronic Disease Management Incentives are payable to the physician who has provided the majority of the patient's longitudinal general practice care over the preceding year. The Chronic Care Incentive bonus fees may be billed once the patient has been provided guideline informed care for one year for that particular condition.

Once successfully billed, the CDM incentives may be billed on or about the anniversary date of the initial billing, provided guideline informed care has continued to be provided in the intervening 12 months.

4. Does obstructive sleep apnea qualify for the COPD CDM (G14053)?

No. COPD and obstructive sleep apnea are two different conditions. Criteria for the diagnosis of COPD are included in the COPD fee description.

5. Will payment item G14050, G14051, G14052 and G14053 replace the usual visit fees for those patients who have diabetes, congestive heart failure, hypertension or COPD?

No. Billing for office visits should continue as usual. This bonus is billed *in addition to* any other fees incurred by usual patient care.

6. Do I have to see the patient on the same day to bill the payment?

You will have to see the patient to provide the necessary clinical care over the year, but you do not have to see the patient on the day of billing the payment. Effective January 1, 2009, there must be at least 2 visits billed on each CDM patient in the 12 months prior to billing the CDM incentive.

7. Do I have to provide all follow up care to the patient face to face?

After successfully billing the G14053 for COPD, some follow up management may be provided to patients by telephone or e-mail, for which you can bill the G14079 GP Telephone/e-mail fee up to 5 times in the following 18 months (in addition to at least 2 face to face visits per 12 months).

8. How does my locum or colleague bill for telephone follow up on my COPD patients when I billed the G14053?

In order to facilitate processing of any claims for telephone/e-mail advice fees by a locum of colleague who has been designated to provide this service, an electronic note should be entered stating "locum for Dr. X billing number YYYYYY".

9. Can I still bill if the patient is in a long-term care facility?

Patients in long-term care facilities are eligible; however clinical judgment may be needed about the appropriateness of following clinical practice guidelines in patients with dementia or very limited life expectancy. If the COPD incentive (14053) is billed for a resident in a long-term care facility a personalized Clinical Action plan must be entered in the patient's chart.

10. Where can I find the clinical guidelines and flow sheets?

The full Diabetes Care, Heart Failure Care, and the Treatment of Essential Hypertension guidelines are found on the Guidelines and Protocols page of the Medical Services Plan web site, along with all other current guidelines.

<http://www.bcguidelines.cahttp://www.healthservices.gov.bc.ca/msp/protoguides/gps/index.html>

A link is also provided on the BCMA web site:

<https://www.bcma.org/gpsc-chronic-disease-management>

The link to information about the flow sheets is also found on the same site. Should you wish to receive a pad of pre-printed flow sheets, please fax your request at the following toll-free fax number 1-800-952-2895.

11. Will other flow sheets be admissible for the bonus?

Other flow sheets can be used if they are consistent with the BC clinical guidelines for diabetes, heart failure, and/or essential hypertension management. It is a requirement to give hypertension patients a copy of their flow sheet as an aid to patient self management. This program is to the usual process of random audit through the Ministry of Health's Billing Integrity Program. Therefore, it is important that you keep all of your completed patient flow sheets on file.

12. Where can I find the COPD Action Plan template?

As part of the patient self management handout, a COPD Care plan template can be found at the end of this document.

13. What supports are available for assisting my patients with COPD who are still smoking to quit?

On September 30, 2011, the B.C. government introduced the BC Smoking Cessation Program that is intended to help eligible B.C residents stop smoking or stop using other tobacco products by assisting them with the cost of smoking cessation aids. The program offers coverage for two treatment options: prescription smoking cessation drugs or non-prescription nicotine replacement therapy (NRT) products. The program is open to eligible B.C. residents who wish to stop using tobacco.

Resources on the B.C. Smoking Cessation Program

Patients may not know about the B.C. Smoking Cessation Program. If patients want to learn about the program, you can refer them to:

- the [B.C. Smoking Cessation Program Patient Information Sheet](#) ^(PDF 488K), an easy-to-print downloadable document that provides a high-level overview of the program
- detailed [smoking cessation program information for patients](#) on the PharmaCare website, including information on eligibility, coverage and registration procedures for the nicotine replacement therapy gums and patches
- HealthLink BC (phone 8-1-1 and ask for the smoking cessation program)

Resources to help patients plan and manage their stop-smoking activities:

The [QuitNow.ca](#) website has a wide range of resources for patients on planning and managing their smoking cessation activities, including:

- information, tips, tools and techniques posted in the [QuitNow library](#)
- access to trained CareCoaches[®]. A phone consultation can be booked at any time of day or night by phoning 8-1-1. More information on CareCoaches[®] is available online at [QuitNow by Phone](#), a free telephone service offering advice, information and support about quitting smoking. The Quitnow Helpline is staffed from 10am to 6pm. After hours and on weekends, callers are invited to leave a message and a Quit Specialist will return the call during service hours.
- the [Quit Now Online](#) community of peer-to-peer support groups
- [QuitNow By TXT](#), a 14-week mobile texting service that provides helpful quit smoking tips and motivational support
- [Demonstration videos](#) on how to use nicotine gum and patches

You can also use Quit Now's [fax referral program](#) to connect patients with counsellors.

Medications covered under the Smoking Cessation program

PharmaCare covers only the following products as part of the Smoking Cessation Program:

1. bupropion (Zyban[®], the brand name version for smoking cessation)
2. varenicline (Champix[®])

3. Thrive™ NRT chewing gum in two strengths
4. Habitrol® NRT patches in three strengths

*Patients are eligible for coverage of one single continuous course of treatment, lasting up to 12 consecutive weeks (84 consecutive days) with either one NRT product or one prescription drug per calendar year. **A Special Authority Form is NOT required for the initial prescription in any given year.** Under exceptional and compelling circumstances, PharmaCare may provide additional coverage. To request additional coverage, physicians are asked to submit a Special Authority request (using the General Special Authority Request form) (PDF 133K) for exceptional case-by-case consideration.*

14. Can I bill the payment even if the clinical or laboratory objectives have not been met?

The payment is provided for the provision of guideline-informed clinically appropriate care which takes account of patient’s values and comorbidities. It is NOT a payment simply because the patient has a diagnosis of diabetes, congestive heart failure, hypertension or COPD.

15. Can I bill for patients covered by other provinces?

Patients covered by other provincial health plans, who are temporarily living in BC are not eligible. In border communities where a BC physician provides the majority of care for an Alberta or Yukon patient, those patients will be eligible.

16. I have assumed the practice of another GP within the last 12 months. May I still bill for patients’ Chronic Disease Management fees?

If the practice you assumed has provided the requisite care to the patient (see bullet 3 in this section) you may bill the Chronic Disease Management payment on its anniversary date. You may not bill the Chronic Disease Management fees if a patient did not receive the requisite level of care, or a chronic disease management fee code has been billed for the patient in the preceding 12 months.

16. Are the payments eligible for the rural premiums?

No.

17. Are general practitioners who are paid by service contract, sessional or salary payments eligible to receive the chronic care bonus payments?

Yes.

CDM Fee Values

G14050	Annual Chronic Care Bonus – Diabetes Mellitus	\$125.00
G14051	Annual Chronic Care Bonus – Congestive Heart Failure	\$125.00
G14052	Annual Chronic Care Bonus – Hypertension	\$50.00
G14053	Annual Chronic Care Bonus – Chronic Obstructive Pulmonary Disease	\$125.00

Billing Scenario

Mr. William S is a 76 year old former smoker who has a past history of Diabetes, hypertension and COPD. You have been his family physician for the past 12 years. When the initial GPSC CDM incentive program began, you had pulled all your charts for eligible patients including Mr. S, and started utilizing the CDM flow sheets for following the care of his diabetes. You see have also been undertaking the complex care management planning visits with Mr. S and find he is due for a CPX as per the guideline recommendations. Mr. S was seen in February for follow up of his diabetes. The Complex Care Management Planning visit was provided in April of this calendar

year. Mr. S has seen you in June and returns in September for his planned CPX in the same month as the anniversary date of his Diabetes CDM. You review his complex care plan and his diabetes management. As well, you provide him with a COPD Action plan for the coming winter. He returns in November for his annual seasonal flu shot given by your office nurse. Later that month, after a visit with his daughter and grandchildren he phones the office with some increased shortness of breath and a change in his sputum but no fever. You advise him on the management of his COPD according to his COPD action plan. You follow up with him at an office visit 2 weeks later. The billings for his management for this calendar year are:

Date	Service Description	Fee Code	Diagnostic Code
Feb	Office Visit	17100	250
April	Complex Care Management Planning Visit	14033 17100	R250 496
June	Office Visit	17100	250
September	CPX plus CDM review and COPD Action Plan update Diabetes CDM COPD CDM	17101 14050 14053	250 250 496
November	Seasonal Flu shot by office nurse	00010	33A
November	Phone Follow up of COPD	14079	496
December	Office Follow up of COPD	17100	496

Chronic Obstructive Pulmonary Disease

A Guide for Patients

Adapted from 2005 GPAC COPD Guideline

Chronic Obstructive Pulmonary Disease (COPD)

Chronic obstructive pulmonary disease includes respiratory disorders such as chronic bronchitis and emphysema that make breathing difficult. Smoking is the most important cause of these diseases. If you smoke, quitting will reduce the severity of the disease and help you improve the quality of life over a much longer time.

Chronic bronchitis and emphysema

In chronic bronchitis, inflammation occurring in the bronchial tubes may cause narrowing, which makes breathing difficult. A chronic cough that brings up sputum is present.

In emphysema, lung tissue and the small air sacs (alveoli) at the end of the airways become damaged and air becomes trapped in the lungs leading to shortness of breath.

COPD Exacerbations

An exacerbation is a worsening of the condition that includes the following signs:

- rapid increase in cough
- mucus production (especially if yellow or green)
- increased shortness of breath
- blue lips or fingers

Exacerbations can be serious and life-threatening. Prompt and effective treatment can help most people recover to the level of breathing before the exacerbation.

Diagnosis

A medical history, physical examination and breathing tests are used to diagnose COPD.

Treatment

Although there is no cure for COPD, the best way to slow the progression of the disease is to quit smoking. Medications may reduce or relieve symptoms. Counseling, education, and exercise can help improve quality of life. Pulmonary rehabilitation programs are available in some areas and these have been proven effective. The use of a COPD Action Plan that has been jointly developed with your physician will assist you in managing your symptoms on a daily basis.

B.C. Smoking Cessation Program

The B.C. Smoking Cessation Program offers British Columbians nicotine replacement therapy products (nicotine gum and patches) at no cost and smoking cessation prescription drugs as benefits under PharmaCare. This program is open to B.C. residents who smoke or use other tobacco products and wish to quit. The program covers two types of smoking cessation aids:

- two prescription smoking cessation drugs, bupropion (brand name Zyban®) and varenicline (brand name Champix®)
 - eligible non-prescription (over-the-counter) nicotine replacement therapy chewing gum or patches
- B.C. residents can get up to 12 continuous weeks (84 continuous days) of coverage for either one NRT product or one prescription drug once every calendar year (January 1 through December 31). Talk to your doctor for more information.

Quitnow

The ***Quitnow*** program has a wide range of resources for patients on planning and managing their smoking cessation activities that are tailored to individual needs. This program is designed for:

- **Smokers who want to quit** can get information about all the different methods, help with deciding what method may be best for them, and what to expect once they quit.
- **People who have just quit** may wish information about coping with withdrawal, and how to manage concerns about things like weight gain or sleep disturbance.
- **Smokers who are thinking of quitting** can discuss the pros and cons with a trained Quit Specialist. And the best thing is: no hassle, no pressure.

- **Smokers who wish to keep smoking** are also welcome to call the line; they don't push anyone to quit smoking and don't judge people for smoking, and a chat may provide useful information.
- **Friends and family members concerned about someone's smoking** are encouraged to call to discuss what they can do to help.

QuitNow resources can be found at quitnow.ca and include:

- information, tips, tools and techniques posted in the [QuitNow library](#)
- access to trained CareCoaches®. A phone consultation can be booked at any time of day or night by phoning 8-1-1. More information on CareCoaches® is available online at [QuitNow by Phone](#).
- the [Quit Now Online](#) community of peer-to-peer support groups
- [QuitNow By TXT](#), a 14-week mobile texting service that provides helpful quit smoking tips and motivational support
- [Demonstration videos](#) on how to use nicotine gum and patches

Living with COPD

Remove factors that can worsen your condition such as smoking. Balance exercise and rest periods. Participation in a pulmonary rehabilitation program or a chronic disease self-management program can be helpful. The BC Lung Association has a list of contacts for Better Breathers clubs in different areas of the province (see web site below) or call **1 800 665-5864** for further information including other programs such as Breathworks **1 866 717-2673**.

Advance Care Planning

On September 1, 2011, B.C.'s new personal planning laws came into effect. B.C.'s updated incapacity planning legislation provides planning tools for capable, adult British Columbians to express their wishes about their future health care, financial, and personal decisions. Personal planning, including making future health care decisions, is as important as making a will, but is often overlooked. Many of us worry about what may happen if, due to illness or injury, we are incapable of expressing our wishes to health care providers. There are options available to help you plan in advance for these times. Talk to your doctor to discuss a plan for your future care. An Advance Directive is a legally binding form that your physician or other health care provider must follow when your instructions address the care you need when you are incapable of giving consent. The advance directive form will be available inside the new provincial advance care planning guide that will be available later in the Fall 2011.

British Columbia Internet Resources

The BC Ministry of Health web site has more detailed information about the management of diseases such as COPD, stop smoking programs and advance care planning.

www.health.gov.bc.ca/cdm/patients

www.health.gov.bc.ca/pharmacare/stop-smoking/patient-intro.html

www.health.gov.bc.ca/hcc/advance-care-planning.html

The BC HealthGuide Online provides detailed information on managing COPD and end of life planning.

<http://bchealthguide.org>

BC Lung Association offers excellent materials for the control of COPD. Contact the BC Lung Association or your local Health Authority for access to a Pulmonary Rehabilitation Program

www.bc.lung.ca





COPD ACTION PLAN



Patient Name: _____ Date: _____
 PHN: _____ Date of Birth: _____
 Family Contact: _____ Phone #: _____
 Physician: _____ Phone #: _____
 After Hours Phone #: _____

You have been diagnosed with **Chronic Obstructive Pulmonary Disease (COPD)**. As someone with COPD, you are either in your stable, everyday state or having a flare up. This Flare up Plan is a written contract between you and your doctor about how you will manage your COPD flare ups. This Plan will help you and your doctor to quickly recognize and treat flare ups to improve your health.

COPD (chronic obstructive pulmonary disease) has 2 states:

When you are am stable:

1. Breathing without shortness of breath
2. Able to do daily activities
3. Mucous is easy to cough up
4. Sleep well
5. Able to exercise as directed by physician

How to tell if you are having a flare up

A flare up may occur after you get a cold, get run down or are exposed to air pollution or very hot or cold weather. There are 3 things that define a flare up:

1. Increased shortness of breath from your usual level
2. Increased amount of sputum from your normal level
3. Sputum changes from its normal colour to yellow, green or rust colour

Some people may feel a change in mood, fatigue or low energy prior to a flare-up.

***If any 2 or all of these symptoms persist for 48 or more hours do the following:
 (Your physician will check the desired action plan for you)***

- Take your rescue inhaler 2-4 puffs as needed (up to 4-6 times per day) for shortness of breath.
- Contact your family doctor immediately for a check up and medication review.
- Take your prescribed antibiotic for a COPD flare up (see over).
- Take your prescribed prednisone for a COPD flare up (see over).
- Contact your doctor if you feel worse **or** do not feel better after 48 hours of treatment.
- Other _____

If you are extremely breathless, anxious, fearful, drowsy or having chest pain, call 911 for an ambulance to take you to the emergency room.

Physician Signature _____

Patient/Caregiver Signature _____ ***Please turn over***

COPD MAINTENANCE MEDICATION RECORD

Patient Name: _____ Date: _____

PHN: _____ Date of Birth: _____

Family Contact: _____ Phone #: _____

Physician: _____ Phone #: _____

After Hours Phone #: _____

Patients: Take the following maintenance medications **every day** to help maintain control of your COPD symptoms.

Physicians: Please fill in prescribed maintenance medications.

Medication Prescribed	How Much to Take	When To Take

COPD FLARE-UP MEDICATION RECORD

Patients: Please fill in date when you start and finish your flare-up medications.

Physicians: Please fill in prescribed flare-up (antibiotics & prednisone) medications.

Medication Prescribed	Start Date / Finish Date	Start Date / Finish Date	Start Date / Finish Date

Make sure to take prescribed medication until all finished.