



**Error-prone Abbreviations, Symbols, and Dose Designations**

**“DO NOT USE” List - Never use when communicating medical information**

Abbreviations ✘	Misinterpretation	What should be used ✓
AD, AS, AU	Mistaken for each other Can be mistaken for OU, OS, OD	“right ear”, “left ear”, or “each ear or both ears”
OD, OS, OU	Mistaken for each other Can be mistaken for AU, AS, AD	“right eye”, “left eye”, or “each eye or both eyes”
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	“micrograms”
cc	Mistaken for U (units) when poorly written	“ml” or “milliliters”
U or u	Mistaken as the number “0” or “4”, causing a 10-fold overdose or greater (e.g., 4U seen as “40” or “44”); mistaken as “cc” so dose given in volume instead of units (e.g., 4U seen as 4cc)	Unit
IU	Mistaken as IV (intravenous) or “10”	International Unit
IN	Mistaken as “IM” or “IV”	Intranasal
SC, SQ, sub q	SC mistaken as SL (sublingual); SQ mistaken as “5 every”; the “q” in “sub q” has been mistaken as “every” (e.g., a heparin dose ordered “sub q 2 hours before surgery” misunderstood as every 2 hours before surgery)	Subcutaneously
Per os	The “os” can be mistaken as “left eye”	PO, orally, or by mouth
D/C	Premature discontinuation of medication if D/C, intended to mean “discharge”, is misinterpreted as “discontinue” when followed by a list of discharge orders.	Discharge or discontinue
HS (half strength or hour of sleep)	Mistaken for each other	Half strength or Bedtime
QD, Q.D., qd, q.d.	Mistaken as “qid”, if the period after the “q” is misunderstood as an “l”.	Daily
QOD, Q.O.D., qod, q.o.d.	Mistaken as “qd” (daily) or “qid” if the “o” is poorly written.	Every other day
QID, Q.I.D., qid, q.i.d.	Mistaken as “qd” if the “l” is misunderstood as a slash mark.	Four times daily
qn or qhs (nightly, at hour of sleep)	Mistaken as “qh” (every hour)	At bedtime
Symbols	Misinterpretation	Correction
°	Mistaken as zero (e.g., q2° seen as q 20)	hour
&	Mistaken for the number “2”	and
@	Mistaken for the number “2”	at
+	Mistaken as “4”	plus or and
/ (slash mark)	Mistaken as the number 1	per
> and <	Mistaken as opposite of intended; used incorrectly	“greater than” or “less than”
Dose Designation	Misinterpretation	Correction
Trailing zero after decimal point * (e.g., 1.0 mg)	Decimal point is missed (e.g., 1.0 mg mistaken as 10 mg if the decimal point is not seen)	Do not use trailing zeros for doses expressed in whole numbers
“Naked” decimal point (No leading zero before a decimal, e.g., .5 mg)	Decimal point is missed (e.g., 0.5 mg mistaken as 5 mg if the decimal point is not seen)	Use zero before a decimal point when the dose is less than a whole unit
Drug Name Abbreviations	Misinterpretation	Correction
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
MgSO <sup>4</sup>	Mistaken as morphine sulfate	magnesium sulfate
MS, MSO <sup>4</sup>	Mistaken as magnesium sulfate	morphine sulfate

\* **Exception:** A “trailing zero” may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes.

1. Drug names should **NEVER** be abbreviated. The use of error-prone abbreviations, symbols, and dose designations is **inadmissible** in the order sheets
2. The use of abbreviations and symbols is **prohibited** in consent forms, pre/post-operative diagnoses in operative reports, and the final diagnosis section of the discharge/decease summary.
3. Chemical symbols are approved abbreviations **EXCEPT** when used in drug names.
4. Abbreviations are accepted if it is included in the AUBMC List of Approved Abbreviations, or is **clearly written in brackets at the point of use after fully spelling out the abbreviated word.**