



# PILL PARCEL LLC

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**FAXED PRESCRIPTIONS ARE TO BE  
SENT TO THE INFORMATION BELOW**  
Fax: 214-380-4475

PATIENT INFORMATION	
PATIENT NAME:	DATE OF BIRTH:
PATIENT PHONE:	GENDER:      MALE      FEMALE
ADDRESS:	PREGNANT:      YES      NO
CITY, ST, ZIP:	DRUG ALLERGY:
PROVIDER INFORMATION	
PROVIDER NAME:	PROVIDER PHONE:
ADDRESS:	PROVIDER FAX:
CITY, ST, ZIP:	NPI:
LAW FIRM INFORMATION	
LAW FIRM NAME:	CASE MANAGER:
DATE OF INJURY:	EMAIL:
ADDRESS:	PHONE:
CITY, ST, ZIP:	FAX:
ORDERS	
<p style="text-align: center;"><b>NSAIDS</b></p> <p>___ Meloxicam 7.5MG      QTY# ___ SIG _____</p> <p>___ Meloxicam 15MG      QTY# ___ SIG _____</p> <p>___ Naproxen 500MG      QTY# ___ SIG _____</p> <p>___ Ibuprofen 400MG      QTY# ___ SIG _____</p> <p>___ Ibuprofen 600MG      QTY# ___ SIG _____</p> <p>___ Ibuprofen 800MG      QTY# ___ SIG _____</p>	<p style="text-align: center;"><b>MUSCLE RELAXANTS</b></p> <p>___ Cyclobenzaprine 5MG      QTY# ___ SIG _____</p> <p>___ Cyclobenzaprine 10MG      QTY# ___ SIG _____</p> <p>___ Methocarbamol 500MG      QTY# ___ SIG _____</p> <p>___ Methocarbamol 750MG      QTY# ___ SIG _____</p> <p>___ Baclofen 10MG      QTY# ___ SIG _____</p> <p>___ Baclofen 20MG      QTY# ___ SIG _____</p> <p>___ Tizanidine 2MG      QTY# ___ SIG _____</p> <p>___ Tizanidine 4MG      QTY# ___ SIG _____</p>
<p style="text-align: center;"><b>TOPICALS</b></p> <p>___ Lidocaine 5% Patch 30 Count      SIG _____</p> <p>___ Diclofenac 3% Gel 100GM Tube      SIG _____</p>	<p style="text-align: center;"><b>GI</b></p> <p>___ Omeprazole 40MG      QTY# ___ SIG _____</p> <p>___ Pantoprazole 40MG      QTY# ___ SIG _____</p>

**PROVDER SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

COMMENTS: