2018 June 14th

- **Dr. Justin Dominick -Sharp Hospital San Diego, California**
  - **Criminal Negligence →**

Dr. Justin Dominick - Sharp Hospital:

With the three ER appointments abroad and much more evidence of Multiple Sclerosis I see Dr. Justin Dominick on June 14th 2018 in Sharp Hospital (the entire hospital is the clearest example of furthering negligence in a clinical setting).
The doctor perpetuates negligence in the clearest way, he denies all medical evidence, lies about MRI series, and tries to downplay the seriousness of the condition. Considering the doctors personal statements and the history of falsified medical data and diagnostics in the US, his recommendation of doing further testing if done in the same hospital in the US would have most likely caused another instance of fraud in a medical setting.

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Consultation.

Name: JANA, NARENDRA NIRMAL **DOB:** 10/27/1984
MRN#: 4723442 **Gender:** M

Note Owner: JUSTIN E DOMINICK
Specialty: Neurology
Date of Encounter: 06/14/2018

Chief Complaint
Reported history of MS

History of Present Illness

Requesting Physician: Dr. Nicholas Dembitsky
Requesting physician is with SRS.
Mr. Jana is a 33-year-old right-handed man originally from Madras, India, who presents for evaluation. He is here alone. He has previously been seen in neurologic evaluation here on several occasions by Dr. Paul Raffer, most recently in May 2017. I reviewed in detail Dr. Raffer's reports. He did not feel that Mr. Jana had MS.

He states that his symptoms started in approximately 2006-2008 with diffuse pain involving his face, palms, hands, arms, and legs with subsequent development of numbness. He also reports generalized weakness throughout his entire body with trouble walking. He states he was having severe headaches. He states he was in "massive physical pain" and states that he was frequently bedridden over the course of 1-1/2 years. He notes that he would have episodes of significant bilateral visual loss in which he could lose anywhere from 40 or 50% up to 80 or 90% of his vision. He states that he had an MRI of the brain and Massachusetts somewhere back in 2008 which revealed an abnormality in the basal ganglia region although no clear diagnosis was made at that time. He notes that an MRI of the brain done in 2012 showed some hyperintense T2 signal posteriorly, which he states he was told by a doctor at the time was the cause of his vision loss. He states that he has had "relapses of MS" lasting 6-7 months, based on the appearance of serial brain MRIs. He states that he has had episodes of pseudobulbar affect. Per review of his records, at one point he apparently was diagnosed with a seizure disorder for which he was treated with Dilantin and carbamazepine. In late 2015, he states that he underwent treatment with IV Solu-Medrol with significant improvement in his headaches and generalized physical pain. In 2016 he underwent FDG PET scan of the brain in Bangkok, Thailand which reportedly revealed findings suggestive of frontotemporal dementia. He states that about 3 months ago while in Thailand, he underwent an additional FDG PET scan of the brain followed by a repeat study 3 days after he completed a course of IV Solu-Medrol, which revealed significant improvement in the results. He states that he was started on Rebif in 2015 while in Mexico which provided him with improvement in his eyesight after he was on the medication for a month. He states that he has been off and on the medication over the past several years secondary to cost. Whenever he is off the medication, his neurologic symptoms get significantly worse including generalized pain, weakness, numbness, coordination difficulties, headache, and vision problems. He states that at one point in the past he had an EEG which revealed "some level of irritation." He has seen various doctors in Germany, Mexico, and Brazil over the years and has had various MRIs done at different facilities. He states that brain MRIs have shown fluctuating levels of T2 hyperintensities posteriorly as well as Dawson's fingers which have significantly diminished on serial subsequent scans after he has been on the rebound. He also states that he has had MRIs of the cervical spine which show cord signal abnormalities as well as cervical spinal cord atrophy. He also reports having atrophy in his spinal cord in the lower lumbar spine at the L5-S1 level (although I told him that the spinal cord does not actually extend that far into the lumbosacral spine). He states that he gets episodes in which the entire left side of his body goes numb although this is a lot better if he is on the Reback. He states that he was started on fingolimod while in Mexico back in

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Patient: JANA, NARENDRA NIRMAL
MRN: 4723442

Date of Encounter: 06/14/2018

October 2017 which she took for a month or so. He continues to take Rebif, but states he is paying for it out of pocket and presents today so that he can be prescribed the medication through SRS. He states that he feels that the serial changes on his MRIs are a consequence of a beneficial effect of the Rebif. No loss of bowel or bladder control.

Allergies
No Known Drug Allergies
Recorded By: GURROLA, DORALICIA; 3/31/2017 10:49:36 AM

Past Medical History
As described above in the HPI

Social History
Exercises rarely (Z78.9)
Never a smoker
Single

No tobacco, alcohol, or recreational drug use. He is single. He works as an engineer. He has a college degree. He was born in India.

Family History
No pertinent family history
No pertinent family history

Review of Systems
Allergy/Immunology, Psychiatric, Cardiovascular, Respiratory, Hematologic/Lymphatic, Gastrointestinal, Genitourinary, Musculoskeletal, Skin and Endocrine review of systems are normal except as stated in the history of present illness or as herein noted: **General:** Lack of energy. **Neurological:** As per HPI. **ENMT:** Difficulty hearing, facial pain. **Eyes:** Blurred vision, loss of vision, eye pain.

Vitals
Vital Signs

	Recorded: 14Jun2018 02:23PM
Blood Pressure	110 / 70, RUE, Sitting
Blood Pressure Method	Manual
Heart Rate	104
Weight	113 lb
BMI Calculated	17.7
BSA Calculated	1.59

Physical Exam

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General: Pleasant, well-groomed man in no acute distress.
Musculoskeletal: Neck was supple.
Cardiovascular: Carotid pulses were 2+ and symmetric, without appreciable bruits. Heart was regular rate and rhythm.

NEUROLOGIC ASSESSMENT:
Mental Status:
He was awake, alert and oriented to himself, the month, day, date, year and place. He gave sufficient detail in his history to demonstrate intact higher integrative function, recent and remote memory, attention span, concentration and fund of knowledge. Speech was spontaneous and fluent, without paraphasic errors.

Cranial Nerves:
Pupils equal, round and reactive to light. Extraocular movements intact. There was no nystagmus. No APD. No INO. Optic disc margins were sharp bilaterally. confrontational visual field testing revealed fluctuating and inconsistent results. Visual acuity with correction was 20/30 -2 left eye, 20/50 right eye. He reported decreased sensation to light touch and pinprick throughout the left V1, V2, and V3 distributions. He reported feeling vibration sensation decreased in the left side of his head and face when a tuning fork was applied to the midline forehead. Facial movement, hearing, palatal elevation were symmetric. Significantly diminished shoulder shrug on the left. Tongue was midline, without atrophy or fasciculations. No dysarthria.

Motor:
Normal tone bilateral upper and lower extremities. He had pronounced pronator drift on the left side with significant tremulousness of his left hand when outstretched in front of him. Strength was 5/5 right-sided shoulder abduction, shoulder adduction, elbow flexion, elbow extension, wrist flexion, wrist extension. There was significant give way weakness throughout testing his left arm which fluctuated. He had significant weakness with a give way component assessing the median and ulnar intrinsics bilaterally. There was significant giveaway weakness throughout assessment of the bilateral lower extremities, left greater than right involving hip flexion, hip extension, hip abduction, hip abduction, knee flexion and extension although he had 5/5 strength with ankle dorsiflexion and ankle plantar flexion on the right although with significant give way weakness testing these on the left.

Sensory:
He reported decreased sensation to light touch and pinprick diffusely throughout the left arm and left leg. Vibration sensation was decreased bilateral upper and lower extremities. He reported feeling decreased vibration sensation on the left side of his body when the tuning fork was applied to his sternum. Normal proprioception in his right foot although impaired in his left foot. No spinal sensory level although he reported not feeling pinprick sensation well throughout the entire left side of his back. Romberg was negative.

Coordination and Gait:
Finger to nose, finger tapping, and rapid alternating movements were slowed and more effortful on the left. Casual gait was narrow based and steady although he moved his left leg more slowly than the right. He was able to tandem walk.

Reflexes:
Trace bilateral biceps, triceps, brachioradialis; 2+ knee jerk on the right versus 1+ on the left; absent to trace bilateral ankle jerks. Plantar responses neutral bilaterally.

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Results/Data

He brought in his laptop computer which had multiple MRIs from various dates from around the world including Germany in Mexico. He showed me various different MRIs including the following:

MRI cervical spine from January 10, 2017 which did not reveal any clear evidence of cord signal abnormality other than some possible artifactual changes. He reported significant spinal cord atrophy although I did not see any significant atrophy.

Cervical spine MRI from September 2017 per my review did not reveal any evidence of significant cord signal abnormality.

Brain MRIs from December 5, 2017, September 2017 and June 2018 all done out of the country, per my review, did not reveal any significant abnormalities, and no evidence of clear demyelination, although he noted that the scans (specifically the sagittal FLAIR images) showed significant T2 abnormal hyperintensity in the bilateral occipital lobes as well as Dawson's fingers.

TSH with Free T4 Reflex **04Apr2017 09:02AM** **DEMBITSKY, NICHOLAS**

Test Name	Result	Flag	Reference
TSH	1.57 microIU/mL		0.35-5.50

The reference range for this TSH assay applies to adults only.

CMP Fasting **04Apr2017 09:00AM** **DEMBITSKY, NICHOLAS**

Test Name	Result	Flag	Reference
Glucose	94 mg/dl		70-100
BUN	17 mg/dl		7-22
Creatinine	0.87 mg/dl		0.55-1.30
Sodium	138 mEq/l		135-145
Potassium	4.6 mEq/l		3.3-5.3
Chloride	100 mEq/l		98-107
Carbon Dioxide	31 mEq/l		21-31
AST	26 Intl_unit/		10-42
ALT	30 Intl_unit/		12-78
ALP	89 Intl_unit/		46-116

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The reference range for this alkaline phosphatase assay applies to adults only. The manufacturer has not established a pediatric reference range and expected values in healthy children may be different.

Bili Total	**0.7 mg/dl**	**<=1.0**
Total Protein	**6.8 g/dl**	**6.4-8.2**
Albumin	**3.7 g/dl**	**3.5-5.0**
Calcium	**8.7 mg/dl**	**8.3-10.1**
eGFR-Black	**>90 ml/min**	**>=60**
eGFR-Non Black	**>90 ml/min**	**>=60**

e GFR Reference Ranges

eGFR Values (mL/min/1.73m2)	Description
Above 60	Normal GFR
30-59	Mild to moderate Kidney damage
15-29	Severe kidney damage
Below 15	Kidney failure

eGFR Calculation and Classification Reference: Annals of Internal Medicine 145(4):247-54, 2006

Hgb A1C **04Apr2017 08:58AM** **DEMBITSKY, NICHOLAS**

Test Name	Result	Flag	Reference
Hgb A1C.	**5.4 %**		**4.5-6.2**

The above reference range was supplied by the test manufacturer. Certain organizations recognize HgbA1c results between 5.7% and 6.4% as prediabetes and results over 6.5 % as diabetes.

Average Bld Glucose **108**

This is a calculated mean glucose value based on the Bernstein Hb-A1c to mean plasma glucose conversion table. This is not an actual glucose value.

Assessment

1. **Numbness and tingling (R20.0,R20.2)**
2. **Weakness generalized (R53.1)**
3. **Headache (R51)**

Plan

Mr. Jana is a 33-year-old right-handed man who presents with a multitude of symptoms dating back to

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Patient: JANA, NARENDRA NIRMAL
MRN: 4723442

Date of Encounter: 06/14/2018

approximately 2006–2008 including headaches, fluctuating vision loss, weakness, trouble walking, numbness, generalized pain, and as described above which he states is secondary to multiple sclerosis. I told him that based on my review of the imaging study results with the brain and cervical spine MRIs that he provided for my review, I do not see any clear evidence to support a diagnosis of multiple sclerosis. I told him that he has multiple abnormalities on his neurologic examination, but there are no findings on his cervical or brain MRIs to clearly account for these abnormalities which I do not think have a definitive clear organic basis. In view of this, I told him that I do not feel comfortable prescribing him a medication for multiple sclerosis when I do not think that he has this diagnosis. Interestingly, he does have diffuse hyporeflexia, the nature of which is not clear, although this would not typically be expected in a patient with significant multiple sclerosis. Although additional neurologic evaluation of his symptoms is warranted, including additional laboratory studies and possible electrodiagnostic testing, at this point, he is primarily interested in continuing with the Rebif for MS and the abnormalities he reports in his imaging studies. As such, I feel that the most prudent course of action at this time would be to have him evaluated by an MS specialist at UCSD Medical Center, which I discussed with him, and to which he is amenable. I do think that he have MRIs of the brain, cervical spine and thoracic spine with and without contrast done here in San Diego either at UCSD or through SRS, and also feel that he should have a lumbar puncture.

Over 50% of the 60 minute encounter was spent dedicated to discussion, counseling, coordination of care, and review of multiple outside imaging studies.

End of Encounter Meds - Meds and allergies reconciled, including those medications given at discharge where applicable. The patient's medication list has been updated accordingly.

Medication Name	Instruction
Rebif 44 MCG/0.5ML Subcutaneous Solution Prefilled Syringe	

Signatures

Electronically signed by : DORALICIA GURROLA, ; Jun 14 2018 2:24PM PST (Co-participant)
Electronically signed by : JUSTIN E DOMINICK, ; Jun 14 2018 5:49PM PST (Author)

This document is privileged and confidential, and is intended for those individuals personally involved in the care of individual patients who may be identifiable from this information. All other use or disclosure is strictly prohibited unless specifically and legally authorized.

Narendra Jana

A statement by statement negation of the medical report is given below:

1

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
Chief Complaint Reported history of MS History of Present Illness Requesting Physician: Dr. Nicholas Dembitsky \. Request ing physician is with SRS Mr. Jana is a 33-year-old right-handed man originally from Madras, India, who presents for evaluation. He is here alone. He has previously been seen in neurologic evaluation here on several occasions by Dr. Paul Raffer, most recently in May 2017. I reviewed in detail Dr. Raffer's reports. He did not feel that Mr. Jana had MS. He states that his symptoms started in approximately 2006-2008 with diffuse pain involving his face, palms, hands, arms, and legs with subsequent development of numbness. He also reports generalized weakness throughout his entire body with trouble walking. He states he was having severe headaches. He states he was in "massive physical pain" and states that he was frequently bedridden over the course of 1-1/2 years.	It is soon determined to be secondary progressive MS, or neurological damage from withholding treatment for MS. The massive physical pain is derived form lesions along the spinal column.

2

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
He notes that he would have episodes of significant bilateral visual loss in which he could lose anywhere from 40 or 50% up to 80 or 90% of his vision. He states that he had an MRI of the brain and Massachusetts somewhere back in 2008 which revealed an abnormality in the basal ganglia region although no clear diagnos is was made at that time. He notes that an MRI of the brain done in 2012 showed some hyperintense T2 signal posterior ly, which he states he was told by a doctor at the time was the cause of his vision loss. He states that he has had "relapses of MS" lasting 6-7 months, based on the appearance of serial brain MRIs. He states that he has had episodes of pseudobu lbar affect. Per review of his records, at one point he apparently was diagnosed with a seizure disorder for which he was treated with Dilantin and carbamazepine. In late 2015, he states that he underwent treatment with IV Solu-Medrol with significant improvement in his headaches and generalized physical pain. In 2016 he underwent FOG PET scan of the brain in Bangkok, Thailand which reportedly revealed findings suggestive of frontotemporal dementia.	ER correlates with visual loss and is recorded. T1 intensity in 2008 is large, 4 square centimeters in size. Its not technically a "relapse" it's a persistent clinical effect from a lack of medications. It was eventually made progressi due to a lack of appropriate medications. Dementia is secondary to MS.

3

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
He states that about 3 months ago while in Thailand , he underwent an additional FOG PET scan of the brain followed by a repeat study 3 days after he completed a course of IV Solu-Medrol , which revealed significant improvement in the results. He states that he was started on Rebif in 2015 while in Mexico which provided him with improvement in his eyesight after he was on the medication for a month. He states that he has been off and on the medication over the past several years secondary to cost. Whenever he is off the medication, his neurologic symptoms get significantly worse includ ing generalized pain, weakness, numbness, coordination difficulties, headache, and vision problems. He states that at one point in the past he had an EEG which revealed "some level of irritation." He has seen various doctors in Germany, Mexico , and Brazil over the years and has had various MRIs done at different facilities. He states that brain MRIs have shown fluctuating levels of T2 hyperintensities posteriorly as well as Dawson's fingers which have significantly dimin ished on serial subsequent scans after he has been on the rebound .	The solumedrol (methylprednisolone) improves the dementia secondary to MS but doesn't make it go away. Indicating optic neuropathy due to MS. T1 intensities diminish but intensities over T2 intensities over the posterior brain, corpus collosum, and mild signs of Dawson fingers never diminish.

4

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
He also states that he has had MRIs of the cervical spine which show cord signal abnormalities as well as cervica l spinal cord atrophy. He also reports having atrophy in his spinal cord in the lower lumbar spine at the L5-S1 level (although I told him that the spinal cord does not actually extend that far into the lumbosacral spine). He states that he gets episodes in which the entire left side of his body goes numb although this is a lot better if he is on the Reback. He states that he was started on fingolimod while in Mexico back in October 2017 which she took for a month or so. He continues to take Rebif, but states he is paying for it out of pocket and presents today so that he can be prescribed the medication through SRS. He states that he feels that the serial changes on his MRIs are a consequence of a beneficial effect of the Rebif. No loss of bowel or bladder control.	The atrophy is eventually determined to be secondary progressive MS. The spinal cord (effecting movement) doesn't extend that far but the disease effects the entire spinal column. The cost of Rebif is over 2k USD in the US per month. The T1 changes are due to medications. T2 changes remain.

5

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
Allergies No Known Drug Allergies Recorded By: GURROLA, DORALICIA; 3/31/201710:49:36 AM Past Medical History As described above in the HPI Social History Exercises rarely (Z78.9) Never a smoker Single No tobacco, alcohol, or recreational drug use. He is single. He works as an engineer. He has a college degree. He was born in India. Family History No pertinent family history No pertinent family history Review of Systems Allergy/Immunology, Psychiatric, Cardiovascular , Respiratory , Hematologic/Lym phat ic, Gastroin testinal, Genitourinary, Musculoskeletal, Skin and Endocrine review of systems are normal except as stated in the history of present illness or as herein noted: General : Lack of energy. Neurological: As per HPI.	

6

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
ENMT: Difficulty hearing, facial pain. Eyes: Blurred vision, loss of vision, eye pain. Vitals Vi ta 1sl-a ns Recorded: 14Jun2018 02:23PM Blood Pressure 110 / 70, RUE, Sitting Blood Pressure Manual Method Heart Rate 104 Weight 113 lb BMI Calculated 17.7 BSA Calculated 1.59 General : Pleasant , well-groomed man in no acute distress. Musculoskeletal: Neck was supple. Cardiovascular: Carotid pulses were 2+ and symmetric , without appreciable bruits. Heart was regular rate and rhythm.	

7

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
NEUROLOGIC ASSESSMENT : Menta l Status: He was awake , alert and oriented to himself, the month, day, date, year and place. He gave sufficient detail in his history to demonstrate intact higher integrative function , recent and remote memory, attention span, concentration and fund of knowledge. Speech was spontaneous and fluent, without paraphasic errors. Cranial Nerves: Pupils equal, round and reactive to light. Extraocular movements intact. There was no nystagmus. No APO. No INO. Optic disc margins were sharp bilaterally. confrontationa l visual field testing revealed fluctuating and inconsistent results. Visual acuity with correction was 20/30 -2 left eye, 20/50 right eye. He reported decreased sensation to light touch and pinprick throughout the left V1, V2, and V3 distribut ions . He reported feeling vibration sensation decreased in the left side of his head and face when a tuning fork was applied to the midline forehead. Facial movement, hearing, palatal elevation were symmetric . Significantly diminished shoulder shrug on the left. Tongue was midline, without atrophy or fasciculations. No dysarthria .	

8

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
Motor: Normal tone bilateral upper and lower extremities. He had pronounced pronator drift on the left side with significant tremulousness of his left hand when outstretched in front of him. Strength was 5/5 right-sided shoulder abduction , shoulder adduction , elbow flexion, elbow extension, wrist flexion , wrist extension. There was significant give way weakness throughout testing his left arm which fluctuated . He had significant weakness with a give way component assessi ng the median and ulnar intrinsics bilaterally. There was significant giveaway weakness throughout assessment of the bilateral lower extremities, left greater than right involving hip flexion, hip extension , hip abduction, hip abduction, knee flexion and extension although he had 5/5 strength with ankle dorsiflexion and ankle plantar flexion on the right although with significant give way weakness testing these on the left. Sensory : He reported decreased sensation to light touch and pinprick diffusely throughout the left arm and left leg. Vibration sensation was decreased bilateral upper and lower extremities.	Left side weakness is correlated with the spinal cord MRI. The "giveway" statement is a statement of "pretense", or he is. pretending. This is eventually shown to be secondary progressive MS that effected his spinal column to the point of a lack of movement. The secondary progressive MS is entirely due to a lack of appropriate medications given when needed.

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06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
He reported feeling decreased vibration sensation on the left side of his body when the tuning fork was applied to his sternum . Normal proprioception in his right foot although impaired in his left foot. No spinal sensory level although he reported not feeling pinprick sensation well throughout the entire left side of his back. Romberg was negative.	The condition was progressing rapidly at that point.
Coordination and Gait: Finger to nose, finger tapping, and rapid alternating movements were slowed and more effortful on the left. Casual gait was narrow based and steady although he moved his left leg more slowly than the right. He was able to tandem walk.	
Reflexes: Trace bilateral biceps, triceps, brachioradialis; 2+ knee jerk on the right versus 1 + on the left; absent to trace bilateral ankle jerks. Plantar responses neutral bilaterally.	

10

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
Results/Data Rees-Stealy ® Medical Group He brought in his laptop computer which had multiple MRIs from various dates from around the world including Germany in Mexico. He showed me various different MRIs including the following:	
MRI cervical spine from January 10, 2017 which did not reveal any clear evidence of cord signal abnormality other than some possible artifactual changes. He reported significant spinal cord atrophy although I did not see any significant atrophy .	The MRI shows a gross medical finding of neurodegeration along the spinal column (cervical) and thoracic.
Cervical spine MRI from September 2017 per my review did not reveal any evidence of significant cord signal abnormality.	The MRIs were introduced to the Sharp system but the doctor or nurse seems to have deleted it from the system.
Brain MRIs from December 5, 2017, September 2017 and June 2018 all done out of the country, per my review, did not reveal any significant abnormal ities, and no evidence of clear demyelination, although he noted that the scans (specifically the sagittal FLAIR images) showed significant T2 abnorma l hyperintensity in the bilateral occipital lobes as well as Dawson's fingers .	The MRIs shows T2 lesions along the posterior brain, corpus collosum, and mild features of Dawsons fingeres (which is unique to MS and indicative of MS)

11

06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
Assessment 1. Numbness and tingling (R20.0,R20.2) 2. Weakness generalized (R53.1) 3. Headache (R51)	
Pl an Mr. Jana is a 33-year-old right-handed man who presents with a multitude of symptoms dating back to approximately 2006-2008 including headaches, fluctuating vision loss, weakness, trouble walking, numbness, generalized pain, and as described above which he states is secondary to multiple sclerosis. I told him that based on my review of the imaging study results with the brain and cervical spine MRIs that he provided for my review, I do not see any clear evidence to support a diagnosis of multiple sclerosis.	Its all typical of MS.
I told him that he has multiple abnormalities on his neurologic examination , but there are no findings on his cervical or brain MRIs to clearly account for these abnormalities which I do not th ink have a definitive clear organic basis.	The evidence couldn't be any clearer.

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06.14.2018-Sharp-Dr. Justin Dominick Summary Original Text	Statement by Statement Negation
In view of this, I told him that I do not feel comfortable prescribing him a medication for multiple sclerosis when I do not think that he has this diagnosis. Interesting ly, he does have diffuse hyporeflexia , the nature of which is not clear, although this would not typically be expected in a patient with significant multiple sclerosis .	
Although additional neurologic evaluation of his symptoms is warranted, including additiona l laboratory studies and possible electrodiagnostic testing, at this point, he is primarily interested in continuing with the Rebif for MS and the abnormalities he reports in his imaging studies. As such, I feel that the most prudent course of action at this time would be to have him evaluated by an MS specialist at UCSD Medical Center, which I discussed with him, and to which he is amenable. I do think that he have MRIs of the brain, cervical spine and thoracic spine with and without contrast done here in San Diego either at UCSD or through SRS, and also feel that he should have a lumbar puncture.	
Over 50% of the 60 minute encounter was spent dedicated to discussion, counseling , coordination of care, and review of multiple outside imaging studies.	