Houston Neuropsychology Associates, PLLC

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NEUROPSYCHOLOGICAL EVALUATION

Name: La Vera Davis
Date of Birth (Age): 6/30/1938 (87)
Ethnicity/Race: African American/Black
Date of Evaluation: 6/1/2026

Education: 20
Handedness: Right
Occupation: Retired
Marital Status: Widowed

This evaluation was conducted for clinical treatment planning and may not be valid for other purposes.

History and Presenting Problem: The following background information was gathered from an interview with the patient and review of available medical records. Ms. La Vera Davis is an 87-year-old, right-handed, African American/Black female referred for neuropsychological evaluation by Leslie Juarez, PA-C, secondary to concern about cognitive decline. MMSE was 26/30 on 6/18/2025.

Cognitively, Ms. Davis' family reported that the patient began experiencing memory issues about four years ago. Her daughter reports that her confusion and forgetfulness have progressed significantly over the past year and are persistent throughout the day. She finds it difficult to remain on topic and frequently loses her train of thought. She exhibits notable confusion with basic tasks, such as dressing. Her daughter explained that she confuses items of clothing and has attempted to wear shirts as pants; this has been a pronounced issue for approximately one year. Furthermore, family members have walked into her room to find her completely undressed. Additionally, her daughter noted instances of severe disorientation upon waking; while the patient indicated this happened once, her daughter feels it has occurred on multiple occasions. Ms. Davis also exhibits "sundowning," characterized by agitation and verbal aggression in the evening, with her daughter frequently being the target of this behavior.

Regarding sensory function, Ms. Davis is legally blind in her right eye secondary to glaucoma, and her left eye fatigues easily. Despite these visual deficits, she was able to see the evaluator and acknowledge print on the wall (though was unable to read it) during the clinical interview. Her hearing is adequate.

Physically, Ms. Davis has a history of six falls last year and one fall this year. She previously experienced falls during the night and currently utilizes bed rails to prevent unassisted nighttime ambulation. Notably, she sustained a fall in August 2025 that required a one-week medical observation; she sustained no fractures and was discharged home without acute rehabilitation services. She has since been placed on hospice care secondary to osteoporosis and severe aortic stenosis (s/p percutaneous coronary intervention), noting that cardiac blockages exacerbate her overall fall risk. Her mobility has progressively deteriorated over recent years. She now requires a wheelchair for community outings and relies on a walker for in-home stabilization, having previously utilized a cane. She often relies on tactile feedback, feeling her surroundings to

stabilize herself. Additionally, she exhibits notable motor restlessness, frequently fidgeting with her legs and clothing.

Functionally, Ms. Davis requires significant assistance. Her family has managed all instrumental activities of daily living (iADLs) for at least the past year. She currently resides with her daughter, son-in-law, and youngest grandson, having lived together for two years. Previously, she lived with her other daughter for two years before that daughter passed away. She requires continuous supervision during the day and night. For bathing, Ms. Davis requires assistance; a CNA visits three times weekly to help. While she can select her clothing, she requires step-by-step instructions for dressing. She has experienced urinary incontinence over the past year. Her daughter has managed her finances for the last two years, as she was previously found to be significantly delinquent on bill payments. She ceased driving several years ago due to legal blindness.

Emotionally, Ms. Davis described her mood as good; however, she prefers to remain at home and exhibits a loss of interest in previous activities. She spends her time sleeping, reading, and conversing on the phone with friends. She reported experiencing complex visual hallucinations, such as seeing her oldest daughter and husband, both of whom passed away 13 years ago. She also described visual misperceptions, such as perceiving a fire hydrant as a dog. Her history of visual hallucinations has increased in frequency over the past six months and is more prominent late in the day. These perceptual disturbances are accompanied by agitation, frustration, and persecutory ideation, where she feels others are accusing her of doing things.

Regarding health habits, Ms. Davis does not consume alcohol, nicotine, or illicit substances, though she has a remote history of smoking. Her appetite is fair; while she was previously losing weight, her weight is currently stable at 86 lbs. She experiences fragmented sleep, noting excessive sleepiness in the evening but frequent awakenings throughout the night.

Additional Medical & Psychiatric History: Ms. Davis's medical history includes hypertension, hyperlipidemia, open angle glaucoma, and cervical radiculopathy. She also has a history of severe aortic stenosis and osteoporosis.

Surgical history is notable for bilateral cataract removal and dentures. She was involved in a motor vehicle accident about 2.5 years ago where she was rear-ended; she reported immediate loss of vision for a "little while" but did not sustain injuries or seek medical attention.

Psychiatric history is remarkable for anxiety and depression; these have been a relatively recent target for treatment (with medication). Her daughter explained that the patient previously served as the caretaker to her spouse and daughter, who passed away within 6 months of one another. Several other loved ones also passed away within a brief time, which reportedly caused emotional distress that was untreated for several years.

Imaging (CT Brain without contrast performed on 05/01/2025) was read to show "No evidence of acute infarct or hemorrhage. Volume loss and chronic small vessel ischemia in white matter. Atherosclerotic calcifications."

Family medical history is notable for dementia in her mother and glaucoma in her maternal aunt.

Medications: amlodipine, gabapentin, trazodone, latanoprost, brimonidine tartrate, citalopram, alendronate sodium, aspirin, baclofen, prednisone, menthol topical analgesic, MiraLax, calcium, and vitamin B.

Psychosocial History: Ms. Davis was born and raised in Cleveland, TX. She is a monolingual English speaker. She denied any learning issues. She completed 20 years of education, earning a doctorate degree (JD) and holding other degrees in fashion design and English.

Vocationally, she worked in oil and gas regulations throughout her career. She is retired.

She has been widowed for 13 years. She has three children, including two daughters who have passed away, and one living daughter. She also has two grandsons and a son-in-law.

Behavioral Observations: Ms. Davis presented to the appointment accompanied by her daughter and son-in-law. She was casually dressed and adequately groomed. She was seated in a wheelchair throughout the appointment. Interpersonally, she was friendly. Her affect was full and appropriate to the setting, and her mood was cheerful. Rapport was established with ease.

Her comprehension was grossly intact. Spontaneous speech was fluent and her thought content was logical. She occasionally lost her train of thought during conversation. She was alert oriented to the day of the week and year. She also correctly identified the current president. She was not oriented to place. While her vision was adequate for engagement in simple, visual-based activities, it was overall deemed to be suboptimal for the purposes of testing, and the test battery was adjusted accordingly. Hearing was adequate.

With regard to test-taking style, Ms. Davis was easily distractible and required frequent prompts and redirection to maintain attention. She occasionally required repetition or clarification of test instructions. She was fully cooperative and completed all activities asked of her.

Results: On standalone and embedded measures of task engagement/performance validity, the patient's performance was below recommended clinical cutoffs, although consistent with a pattern seen in individuals with genuine memory impairment.

Performance descriptors follow the American Academy of Clinical Neuropsychology consensus statement on uniform labeling of test scores.

Domain	Test Name	Raw Score	Descriptor
Dementia Screen	DRS-2 Total	86	Exceptionally Low
	DRS-2 Attention	33	Average
	DRS-2 Initiation/Perseveration	14	Exceptionally Low
	DRS-2 Construction	3	Low Average
	DRS-2 Conceptualization	24	Below Average
	DRS-2 Memory	12	Exceptionally Low
Auditory Attention	WAIS-IV DSF	9	Average
	WAIS-IV DSB	4	Low Average
	WAIS-IV DSS	2	Low Average
Visual Attention & Processing Speed	Oral Trail Making Test-1	10 seconds	High Average
Language	WRAT-5 Word Reading	50	Low Average
	NAB Naming	9	Exceptionally Low
	Animal Naming	7	Below Average
Learning & Memory	RBANS List Learning (3-4-5-7)	19	Low Average
	RBANS List Recall	4	Within Normal Limits
	RBANS List Recognition	19	Within Normal Limits
	RBANS Story Memory	11	Low Average
	RBANS Story Recall	2	Below Average
Executive Functioning	FAS	17	Below Average
	Oral Trail Making Test-2	D/C @ 69 sec (4 errors)	---
	CLOX-1	3	Exceptionally Low
	CLOX-2	5	Exceptionally Low
Self-Report	GDS	16	Mild symptoms of depression

Impressions: Performance on the current neuropsychological evaluation is interpreted within the context of premorbid ability, which is estimated to be at least within the high average range based upon reported academic/vocational achievement and performance indicators.

On a dementia screening measure, Ms. Davis' overall score was in the exceptionally low range. While basic attention and construction were within the average to low average range, her performance within the domains of initiation/perseveration, conceptualization, and memory were below average to exceptionally low.

Ms. Davis performed within the average range on digit repetition, but digit reversal and sequencing were in the low average range.

Speeded numerical sequencing was high average but she was unable to complete a task involving alphanumerical sequencing, committing multiple errors.

Single word reading was low average and verbal fluency (semantic and phonemic) was below average. Confrontation naming was exceptionally low.

Acquisition of unstructured verbal information was low average and recall and recognition were within normal limits. Story learning was low average and recall was below average.

When prompted to draw a clock, she produced a series of numbers. Provided with an example, she showed a prominent visuospatial planning/organization deficit, where suboptimal vision may have also contributed.

From an emotional standpoint, Ms. Davis endorsed clinically elevated symptoms of depression.

Summary: Ms. Davis presents with significant cognitive and functional decline that has progressively worsened over the last four years. Behaviorally and functionally, she exhibits profound memory impairment, disorientation, visual hallucinations, and sundowning characterized by evening agitation. Objective neurocognitive testing revealed exceptionally low global cognitive functioning on a dementia screening tool, driven by significant impairments in memory and executive functioning (initiation/perseveration). She also exhibited marked impairments in confrontation naming and speeded set-shifting, with relative sparing of simple auditory and visual attention. Of note, it is important to consider the impact of suboptimal vision on her current presentation. While her visual acuity was adequate for a basic level of engagement, it is likely that her visual deficits negatively impacted her performance on visually mediated tasks to some degree. She is entirely dependent on her family and visiting home health staff for both instrumental and basic activities of daily living, including finances, medication management, dressing, and bathing. Integration of her clinical history and objective cognitive difficulties warrants a diagnosis of moderate dementia. The etiology of cognitive decline is likely due to multiple etiologies, including suspected Alzheimer's and vascular disease.

Diagnosis: Dementia Due to Multiple Etiologies (Alzheimer's and Vascular Disease), Moderate, With Behavioral Disturbance.

Recommendations:

1. **Safety and Supervision:** Given her moderate dementia and high level of dependence for basic and instrumental activities of daily living, Ms. Davis should receive continuous 24-hour supervision to ensure her safety and well-being. Her family should continue to manage her finances, medications, and personal hygiene.

2. **Fall Precautions and Mobility:** Due to her history of frequent falls, cardiac blockages, and deteriorating mobility, strict fall precautions should be maintained. The continued use of bed rails at night is advised to prevent unassisted nighttime ambulation. She should continue utilizing her wheelchair for community outings and her walker for in-home stabilization.

3. **Visual Impairment Accommodations:** Because Ms. Davis is legally blind in her right eye and relies heavily on tactile feedback to navigate, her living environment should be kept strictly free of clutter, loose rugs, and electrical cords to mitigate trip hazards.

4. **Symptom Management (Hallucinations & Sundowning):** Ms. Davis experiences complex visual hallucinations, persecutory ideation, and evening agitation (sundowning). Caregivers are encouraged to utilize gentle redirection, validation, and distraction techniques rather than attempting to correct her reality. Maintaining a calm, well-lit, and low-stimulation environment in the late afternoon and early evening may help mitigate sundowning symptoms.

5. **Medical and Psychiatric Follow-Up:** She should continue close follow-up with her medical providers and her hospice care team to manage her cardiac condition, osteoporosis, and behavioral symptoms. Her mood and symptoms of depression and anxiety should continue to be monitored and pharmacologically managed as needed.

6. **Caregiver Support:** Caring for a loved one with progressive dementia and complex medical needs is highly demanding. Her family is strongly encouraged to engage in routine self-care to prevent burnout and to utilize available support services through hospice. The Alzheimer's Association (www.alz.org) is also an excellent resource for education, care planning, and emotional support.

Thank you for the opportunity to participate in this patient's care.

Aimee Giammittorio, Ph.D.
Licensed Psychologist

Electronically signed: 6/2/2026.