

Houston Neuropsychology Associates, PLLC

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NEUROPSYCHOLOGICAL EVALUATION

Name: Elvey Richard
Date of Birth (Age): 7/28/1938 (87)
Ethnicity/Race: Caucasian/White
Date of Evaluation: 6/3/2026

Education: 13
Handedness: Left
Occupation: Retired
Marital Status: Married

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 a clinical interview with the patient, a collateral interview with the patient's wife and daughter, and a review of available medical records. Mr. Elvey Richard is an 87-year-old, left-handed, Caucasian male referred for neuropsychological evaluation by Alix Halter, FNP-C, secondary to concern about cognitive decline. His MMSE was 23/30 on 3/16/2026.

Cognitively, Mr. Richard's family has observed a progressive decline in his thinking over the past 18 months. His daughter assumed full responsibility for completing his taxes in January 2025, at which time he reportedly exhibited prominent word-finding difficulties and impaired comprehension. He also expressed the delusional belief that he owned multiple homes. He was diagnosed with diabetes in April 2023; his family noted no significant cognitive changes at that time aside from difficulty recalling actors' names. Approximately one year ago, he began hiding items, such as his wallet, within the home. By Summer 2025, he required continuous supervision due to confusion/memory loss, though he retained the ability to recognize family members. Over the past four to five months, Mr. Richard has shown persistent confusion regarding the identities of his immediate family members, frequently misidentifying his wife and daughter as his sister. He has also routinely experienced non-threatening visual hallucinations of his deceased parents, as well as other people. Emotionally, his mood is generally stable and euthymic, with occasional irritability stemming from receptive language difficulties.

Functionally, Mr. Richard ceased driving one year ago due to spatial disorientation. He bathes independently once weekly and his overall hygiene remains adequate. He experiences nocturnal urinary incontinence. His wife manages all household chores and meal preparation; he previously assisted with minor kitchen cleanup but no longer does so. His family administers his medications, and his daughter manages the finances.

Physically, he reports increased difficulty rising from a seated position but denies a history of falls; he ambulates on a treadmill daily for six minutes. Regarding sensory function, he utilizes bilateral hearing aids, though they provide suboptimal correction. He wears prescription corrective lenses and has unextracted bilateral cataracts, as his family has opted against surgical intervention at this time.

Regarding health habits, Mr. Richard has a remote history of nicotine and alcohol use, with no reported history of abuse. He has never used illicit substances. His appetite remains robust. He reported adequate sleep, but his family describes significant nocturnal wandering; he has attempted to elope from the home on two occasions, prompting his family to install a bed motion detector to alert them to his nighttime ambulation. He frequently naps in his chair during the daytime.

Medical & Psychiatric History: Medical history is remarkable for hyperlipidemia, hypertension, diabetes, benign prostatic hypertrophy, chronic kidney disease (Stage 3a), eczema, psoriasis, cataracts, and hearing loss.

Surgical history is notable for a colon polypectomy.

Psychiatric history is unremarkable.

A CT of the head (performed on 3/24/2026) was read to show, “No acute intracranial abnormality. Advanced small vessel white matter disease.”

Family medical history is notable for hypertension in his mother. His father had cardiac surgery followed by a dementia syndrome. His brother had Alzheimer's disease and passed away at age 81.

Medications: pioglitazone, metformin, fenofibrate, omeprazole, metoprolol, pravastatin, mirtazapine, famotidine, fluticasone, and multiple vitamins.

Psychosocial History: Mr. Richard demonstrated poor autobiographical recall. He was born and raised in Louisiana. He is bilingual in French (spoken by his parents) and English, having learned the latter during his early academic years. He denied history of learning disorder or grade retention. He graduated from high school and completed one year of college. He served in the Air Force for four years. Vocationally, he worked as an accountant. He is currently retired.

Mr. Richard has been married for 57 years, though he expressed confusion regarding his marital history during the interview. He has a daughter and son.

Behavioral Observations: Mr. Richard arrived on time for his appointment, accompanied by his wife and daughter. He was casually dressed, adequately groomed, and ambulated independently. He was alert but disoriented to time and place. Although he correctly identified the year and the date, he was unable to accurately state the current month or day of the week.

Interpersonally, he was friendly, and his affect was broad and appropriate to the clinical setting. His spontaneous speech was clear and fluent; however, conversational engagement was limited by prominent episodic confusion. For example, when queried about his morning routine, he asked, “Breakfast? What do you mean by breakfast?” yet later utilized the word spontaneously in conversation. Due to his need for frequent repetition and simplification of information, most of his clinical history was obtained via a collateral interview with his family.

Regarding his test-taking approach, Mr. Richard was easily engaged. He was agreeable to utilizing a clinical hearing amplifier, which provided adequate auditory correction for testing purposes. While he occasionally required repetition and clarification of task instructions, he remained highly cooperative and diligently attempted all activities requested of him.

Results: Mr. Richard scored within expected limits on measures of task engagement/performance validity. Cognitive results are considered valid.

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	106	Exceptionally Low
	DRS-2 Attention	37	Above Average
	DRS-2 Initiation/Perseveration	18	Exceptionally Low
	DRS-2 Construction	6	Average
	DRS-2 Conceptualization	34	Average
	DRS-2 Memory	11	Exceptionally Low
Auditory Attention	WAIS-IV DSF	11	High Average
	WAIS-IV DSB	7	Average
	WAIS-IV DSS	1	Below Average
Visual Attention & Processing Speed	Trail Making Test- A	100 seconds	Exceptionally Low
	RBANS Coding	12	Exceptionally Low
Language	WRAT-5 Word Reading	65	High Average
	NAB Naming	18	Exceptionally Low
	FAS	3	Exceptionally Low
	Animal Naming	8	Exceptionally Low
Learning & Memory	RBANS List Learning (0-0-3-3)	6	Exceptionally Low
	RBANS List Recall	0	Low Average to Below Average
	RBANS List Recognition	12	Below Average to Exceptionally Low
	RBANS Story Memory	1	Exceptionally Low
	RBANS Story Recall	0	Exceptionally Low
Visual Memory	RBANS Figure Recall	0	Exceptionally Low
Visuospatial	RBANS Figure Copy	16	Average
	RBANS Line Orientation	15	Within Normal Limits
Executive Functioning	Trail Making Test- B	D/C @ Sample	---

	CLOX-1	3	Exceptionally Low
	CLOX-2	10	Low Average
Self-Report	GDS	2	Within Normal Limits

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

On a dementia screening measure, Mr. Richard’s overall score fell in the exceptionally low range. While basic attention, conceptualization, and construction were broadly intact, his performance within the domains of initiation/perseveration and memory were exceptionally low.

Mr. Richard demonstrated a relative preservation of simple auditory attention, scoring in the high average range for digit repetition and average for digit reversal. However, more complex, working memory-dependent manipulation of digits (sequencing) was below average.

He exhibited severe impairments across most other cognitive domains. Within the domain of language, confrontation naming and verbal fluency (semantic and phonemic) were exceptionally low. Visual attention and processing speed was exceptionally low on numerical sequencing and symbol/digit transposition tasks.

Within the domain of learning and memory, Mr. Richard showed a profound amnesic profile. Acquisition of unstructured verbal information and structured stories was exceptionally low, followed by nil delayed free recall for both modalities, and impaired recognition of story details. Visual memory was similarly impaired, with nil free recall of a previously copied complex figure.

Visuoconstruction of a complex figure and judgment of angular line relations remained relatively intact.

Executive functioning was markedly compromised. He was unable to demonstrate understanding of a complex set-shifting task, which was ultimately discontinued despite additional teaching and simplification. His spontaneous clock drawing was exceptionally low, indicative of deficits in visuospatial planning and cognitive organization; clock copy was marked by mild imprecision.

From an emotional standpoint, Mr. Richard denied symptoms of depression on a formal self-report measure.

Summary: Mr. Richard presents with a severe and progressive cognitive and functional decline evolving over the past 18 months. Behaviorally and functionally, he exhibits profound memory impairment, spatial disorientation, nocturnal wandering, confusion of family members, and visual hallucinations and delusions. Objective neurocognitive testing revealed exceptionally low global cognitive functioning, driven by profound amnesic deficits, severe executive dysfunction, and markedly impaired expressive language/naming. He is highly dependent on his family for instrumental activities of daily living, including financial management, medication administration, and transportation.

Integration of his clinical history, rapid functional decline, prominent behavioral disturbances, and objective neuropsychological deficits warrants a diagnosis of dementia. The clinical presentation and trajectory are highly consistent with Alzheimer's disease, with suspected contribution from vascular factors given his medical history and evidence of advanced small vessel white matter disease identified on recent neuroimaging.

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

Recommendations:

1. **Safety and Supervision:** Considering his degree of cognitive impairment and delusions, Mr. Richard should continue to receive support and oversight with basic and instrumental activities of daily living to optimize safety and well-being. In particular, his family should continue to administer his medications and manage financial affairs. A trusted individual is recommended to continue coordinating his medical care, accompanying him to appointments, and being involved in decisions concerning his welfare. Continued driving cessation is advised.
2. **Wandering Precautions:** Given his history of wandering and attempts to leave the house at night, continued use of a motion detector is highly recommended.
3. **Audiology Follow-Up:** Mr. Richard is strongly encouraged to follow up with an audiologist to evaluate and adjust his bilateral hearing aids, which are reportedly not working well. He required an amplifier and frequent repetition during the evaluation to aid comprehension. Optimizing his hearing is critical, as uncorrected sensory deficits can exacerbate confusion and cognitive fatigue.
4. **Communication Strategies:** Family and caregivers may find the following strategies beneficial for communication and overall functioning:
 - Use brief instruction and provide repetition often. His retention of information should not be assumed in any communication.
 - Display information, such as the day, date, and time, on a calendar or information board that is kept in a central location.
 - Utilize routines to provide predictability. Specifically, set a routine wake/sleep schedule and designate times for personal hygiene, meals, and activities.
 - Label locations of where items are stored (e.g., drawers and cabinets in the kitchen or bathroom).
5. **Delusion and Hallucination Management:** Mr. Richard experiences visual hallucinations of deceased parents and expresses delusional beliefs regarding his home and the identities of his wife and daughter. Because he does not currently feel threatened by these experiences, caregivers are encouraged to utilize gentle redirection, distraction, and validation techniques. Continuously attempting to correct his reality or arguing with him should be avoided, as this can increase frustration and irritability. If these symptoms begin to cause him distress or

become unsafe, pharmacological management may be considered in consultation with his referring provider.

6. **Future Planning:** The current findings may serve as an impetus for Mr. Richard and his family to ensure that his affairs are in order. Designation of durable power of attorney for health care and financial matters, as well as the establishment of a will and advance directive, would be prudent if not yet completed or up to date.
7. **Caregiver Support:** Caregivers are strongly encouraged to engage in routine self-care to promote emotional well-being and the ability to care for their loved one. Support groups are a great source of information and emotional support. The Alzheimer's Association (www.alz.org or 713-314-1313) is a recommended resource.

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

Aimee Giammittorio, Ph.D.

Licensed Psychologist

Electronically signed: 6/4/2026.