

## Houston Neuropsychology Associates, PLLC

Phone: 713-893-7105 • Fax: 713-893-7145 • Email: office@houston-npa.com • <https://houston-npa.com>

### **Neuropsychological Evaluation**

**Name:** Laurence Smith

**Referral Source:** Hassan Javanshir, M.D.

**Date of Birth:** 9/18/48

**Date of Evaluation:** 7/8/26

**Reason for Referral:** Mr. Smith's neurologist referred him for neuropsychological evaluation due to suspected cognitive decline. Results will elucidate his current level of functioning to inform diagnostic decision-making and treatment planning.

**Functions Assessed and Instruments Employed:** Clinical interview with the patient and his wife, Medical History Questionnaire, Test of Nonverbal Intelligence – 4 (TONI-4), Token Test (MAE), Sentence Repetition, Peabody Picture Vocabulary Test – 4 (PPVT-4), NAB Naming Test, Word Reading (WRAT-5), Dementia Severity Rating Scale, Activities of Daily Living Scale, and Neuropsychiatric Inventory – Questionnaire.

#### **Identifying Information:**

The following information comes from a clinical interview with Mr. Smith and his wife, as well as a review of available medical records. Mr. Smith is a 77-year-old, right-handed, married Caucasian male with 16 years of education.

**Presenting Problems:** Mr. Smith was in his usual state of health until 11/21/25. At that time, he developed altered mental status, difficulty expressing himself, and right hemiparesis. He also noted that his vision “blacked out” briefly. An ambulance took him to a hospital. Although he was within the TNK window, the treatment was withheld because a CT scan of the head (11/21/25) reported an age-indeterminate recent subacute or chronic right lateral temporal infarct, rendering him ineligible. He was in the ICU for 5-6 days and an additional one to two days in a step-down unit before transferring to inpatient rehabilitation, where he participated in physical, occupational, and speech therapies until 12/16/25. He then completed five outpatient physical therapy sessions and is currently participating in speech therapy twice a week.

Since the stroke, Mr. Smith reported having problems with his verbal expression. "I know something, but I can't commute [sic]." His wife corroborated his ongoing issues with speech, noting, "He knows what he wants to say but he can't say it." She indicated that his responses are often difficult to understand and nonsensical. She added that he often forgets information told to him and needs reminders. Although these problems have gradually improved since the stroke, they indicated that he has not returned to his baseline.

Mr. Smith denied experiencing mood disturbance. He has difficulty initiating and maintaining sleep, though his energy level is adequate. His appetite and weight are stable. He denied suicidal ideation.

He stopped driving following the aforementioned stroke in November 2025. Additionally, his wife now assists with medications, finances, telephone usage, shopping, meal preparation, housekeeping, and laundry. He is independent for physical self-maintenance tasks.

**Medical History:** In addition to the aforementioned stroke, he has hypertension, hyperlipidemia, macular degeneration, and uncorrected hearing loss.

An MRI of the brain (11/21/2025) reported an acute infarct in the left parieto-occipital lobe, and old infarcts in the left occipital, lateral right temporal, lateral right high frontal lobes, and right centrum semiovale. A CT of the head (11/25/2025) reported expected evolution of a recent infarct in the left parietal lobe and left occipital lobe.

Surgeries: benign liver biopsy, right underarm skin excision, right foot repair, and right cataract removal. Although medical records indicated that a thrombectomy was not pursued, Mr. Smith's wife reported that he underwent a left thrombectomy.

Current medications: clopidogrel, atorvastatin, amantadine, donepezil, and tamsulosin.

Substance use: He smoked two packs of cigarettes daily before transitioning to an electronic cigarette, which he quit using after the stroke. According to his wife, he consumed one three-liter box of wine every two days prior to the stroke. He denied current alcohol consumption. He denied a history of recreational drug use.

Family history: His mother had diabetes and hypertension; she died at 98 from causes unknown to him. His father died at 84 from lung cancer. He has two brothers and two sisters. One brother died from drowning. One sister had diabetes and died from breast cancer. His other sister also has diabetes.

**Mental Health History:** He denied a history of mental health diagnosis and treatment.

**Educational History:** Mr. Smith completed a bachelor's degree in electrical engineering at Lamar University. He reported earning average grades in school. He denied a history of grade retention and specific learning disorder.

**Occupational History:** He served in the US Marines for four years. He then worked as an electrical engineer. He retired in June 2025.

**Social History:** Mr. Smith was born in Beaumont, TX. He has been married for 16 years. He lives with his wife. He was married and divorced twice previously. He has two sons and two daughters.

**Behavioral Observations:**

Mr. Smith presented as a nicely dressed, well-groomed gentleman. He ambulated independently and wore prescription glasses. Mood was pleasant and affect was broad. Speech was dysarthric and sparse. During the test session, the examiner had to provide frequent elaboration, simplification, and repetition of test instructions, as well as additional structure. His information processing speed was extremely slow. Due to the extent of his receptive and expressive language impairments, the planned test battery was shortened considerably. It was not possible to assess all cognitive domains. Mr. Smith was cooperative. Results appear to provide an accurate representation of his current level of neuropsychological functioning.

**Results:**

Mr. Smith obtained a TONI-4 score of 88, which falls within the low average range. On a test requiring comprehension and execution of actions to command by shape, size, color, and syntax, he was able to follow only three simple one-step commands (e.g., point to a circle). However, his performance deteriorated with more complex commands (e.g., point to a yellow square). He was unable to repeat extremely short sentences (e.g., "Take this home."). Visual object naming was exceptionally low, and his responses often did not pertain to the stimulus items. Oral word reading was exceptionally low as well. In contrast, receptive word knowledge was low average.

**Impression:** Vascular Dementia, Moderate Severity

Mr. Smith's neuropsychological evaluation was limited due to his receptive and expressive aphasia. He demonstrated diffuse and severe cognitive impairment, including in receptive and expressive language, and word reading. Given the fundamental impairments in language comprehension and expression, assessment of cognitive functions in other domains was not practical.

In contrast, he demonstrated relatively well-preserved nonverbal intellectual functioning and receptive word knowledge. His performance in these areas fell within the low average range, which nevertheless likely reveals slight declines.

Mr. Smith's history and current test data reveal multiple cognitive impairments that represent a significant decline from his estimated premorbid level, which correlate with difficulty performing numerous instrumental activities of daily living independently. A diagnosis of moderate dementia is warranted. Global aphasia was the most salient aspect of his profile. The present data appear to be consistent with a cerebrovascular etiology given his medical history that includes a recent CVA and several vascular risk factors.

**Recommendations:**

1. Mr. Smith's comprehension and recall of information should not be assumed in any conversation or other communication. He probably lacks the capacity to make competent decisions concerning his personal affairs. A family member or trusted associate should accompany him to all doctor visits and other important meetings. Activation of durable power-of-attorney or guardianship arrangements would be reasonable.
2. The extent of his dementia suggests a need to plan in terms of his living situation and future health care needs. His family members may wish to consider in-home health care services or assisted living options. He should not be left alone for long periods of time and probably needs 24-hour care. His access to potentially dangerous household appliances should be restricted.
3. He should continue not to drive. He will need ongoing assistance with managing his medications, finances, and all personal affairs.
4. Regular physical exercise, such as walking with a partner or using stationary fitness equipment with supervision is recommended for its beneficial effects on brain health and cognitive maintenance.

5. It will be important for the patient to have opportunities to socialize with others. He may also enjoy nostalgia-oriented materials for recreational purposes (e.g., old movies and music). Although he will have difficulty following new movies and programs, he may enjoy listening to those with which he is already familiar.

6. His family members might benefit from enrollment in a support group for caregivers of persons with dementia. The Family Caregiver Alliance ([www.caregiver.org](http://www.caregiver.org)) is a recommended resource.

Dr. Javanshir, thank you for this kind referral. If we may be of further assistance, please do not hesitate to contact us.

*Allison G. Miley*

Allison G. Miley, M.A., LPA  
Licensed Psychological Associate

*Robert N. Davis*

Robert N. Davis, Ph.D., ABPP  
Board Certified, American Board of Clinical Neuropsychology

Electronically signed: 7/10/26.