Keck School of Medicine of USC

DEPARTMENT OF PSYCHIATRY AND THE BEHAVIORAL SCIENCES

Joey W. Trampush, Ph.D.
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NEUROCOGNITIVE EXAMINATION

CASE NUMBER: 123456
PATIENT NAME: Smalls, Biggie
DATE OF BIRTH: YYYY-MM-DD, Age 20
DATE(S) OF EXAM: YYYY-MM-DD, YYYY-MM-DD, and YYYY-MM-DD
DATE OF REPORT: 2025-01-20

TESTS ADMINISTERED

- Comprehensive Neuropsychiatric Symptom and History Interview
- Conners' Adult ADHD Diagnostic Interview for DSM-IV, Part I: History (CAADID Part 1)
- Conners' Adult ADHD Diagnostic Interview for DSM-IV, Part II: Symptoms (CAADID Part 2)
- Structured Clinical Interview for DSM-5 Disorders, Clinician Version (SCID-5-CV)
- Beck Anxiety Inventory (BAI)
- Beck Depression Inventory, 2nd ed (BDI-2)
- Brown Executive Function/Attention Scales, Parent Report (Brown EF/A Parent)
- Brown Executive Function/Attention Scales, Self-Report (Brown EF/A Self)
- Brown Executive Function/Attention Scales, Teacher Report (Brown EF/A Teacher)
- California Verbal Learning Test, 3rd ed (CVLT-3), Standard Form
- California Verbal Learning Test, 3rd ed, Brief Form (CVLT-3 Brief)
- Childhood Autism Rating Scale, 2nd ed, High-Functioning Version (CARS-2 HF)
- Comprehensive Executive Function Inventory, Adult, Observer (CEFI Adult Observer)
- Comprehensive Executive Function Inventory, Adult, Self-Report Form (CEFI Adult Self-Report)
- Conners' Adult ADHD and Executive Function Rating Scales, 2nd ed, Self-Report (CAARS-2 Self)
- Conners' Adult ADHD and Executive Function Rating Scales, 2nd ed, Observer Report (CAARS-2 Observer)
- Conners' Adult ADHD Rating Scales–Observer Report: Long Version (CAARS–O:L)
- Conners' Adult ADHD Rating Scales–Self-Report: Long Version (CAARS–S:L)
- Delis-Kaplan Executive Function System (D-KEFS):
  - Color-Word Interference
  - Trail Making
  - Design Fluency
  - Verbal Fluency
- Dot Counting Test (DCT)
- Grooved Pegboard Test
- Repeatable Battery for the Assessment of Neuropsychological Status (RBANS)

- Repeatable Battery for the Assessment of Neuropsychological Status, Update, Form A (RBANS Update Form A):
  - Immediate Memory
  - Language
  - Visuospatial/Constructional
  - Attention
  - Delayed Memory
- Repeatable Battery for the Assessment of Neuropsychological Status, Form B (RBANS)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form C (RBANS)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form D (RBANS)
- Rey-Osterrieth Complex Figure Test (ROCFT)
- Trail Making Test (TMT)
- Wechsler Adult Intelligence Scale, 4th ed (WAIS-IV)
- Wechsler Adult Intelligence Scale, 4th ed (WAIS-IV): Similarities, Matrix Reasoning, Letter-Number Sequencing, Coding, Symbol Search, Digit Span, Vocabulary, Block Design, Figure Weights, Arithmetic, Cancellation
- Wechsler Adult Intelligence Scale, 5th ed (WAIS-5)
- Wechsler Individual Achievement Test, 4th ed (WIAT-4)
- Wechsler Individual Achievement Test, 4th ed (WIAT-4): Word Reading, Reading Comprehension, Pseudoword Decoding, Orthographic Fluency, Decoding Fluency
- Wechsler Memory Scale, 4th ed (WMS-4)
- Wechsler Memory Scale, 4th ed (WMS-4): Logical Memory, Verbal Paired Associates, Visual Reproduction, Visual Paired Associates, Designs, Spatial Addition, Symbol Span, Spatial Span
- Wide Range Achievement Test, 5th ed (WRAT-5)
- Wide Range Achievement Test, 5th ed, Blue Form (WRAT-5): Word Reading
- Wide Range Achievement Test, 5th ed, Green Form (WRAT-5): Word Reading
- NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Research (NIH EXAMINER):
  - Behavioral Rating Scale
  - Word Fluency
  - Unstructured Task
- Advanced Clinical Solutions (ACS):
  - Word Choice Test
  - Test of Premorbid Functioning (TOPF)
  - Social Cognition
- Neuropsychological Assessment Battery (NAB):
  - Attention Module
  - Language Module
  - Memory Module
  - Spatial Module
  - Executive Functions Module
- Neuropsychological Assessment Battery, Screener (NAB-S):
  - Attention Module
  - Language Module
  - Memory Module

  - Spatial Module
  - Executive Functions Module
- Neuropsychological Assessment Battery (NAB):
  - Judgment
- Hare Psychopathy Checklist, Revised (PCL-R)
- Personality Assessment Inventory (PAI)
- Comprehensive Neurodevelopmental Symptom and History Interview
- Behavioral Assessment System for Children, 3rd ed, Structured Developmental History (BASC-3 SDH)
- Kiddie-SADS
- Adaptive Behavior Assessment System, 3rd ed, Parent Form (ABAS-3 Parent)
- Adaptive Behavior Assessment System, 3rd ed, Parent/Primary Caregiver Form (ABAS-3 Parent)
- Adaptive Behavior Assessment System, 3rd ed, Self-Report Form (ABAS-3 Self)
- Adaptive Behavior Assessment System, 3rd ed, Teacher Form (ABAS-3 Teacher)
- Behavioral Assessment System for Children, 3rd ed, Parent Rating Scales, Adolescent (BASC-3 PRS Adolescent)
- Behavioral Assessment System for Children, 3rd ed, Parent Rating Scales, Child (BASC-3 PRS Child)
- Behavioral Assessment System for Children, 3rd ed, Parent Rating Scales, Preschool (BASC-3 PRS Preschool)
- Behavioral Assessment System for Children, 3rd ed, Self-Report of Personality, Adolescent (BASC-3 SRP Adolescent)
- Behavioral Assessment System for Children, 3rd ed, Self-Report of Personality, Child (BASC-3 SRP Child)
- Behavioral Assessment System for Children, 3rd ed, Teacher Rating Scales, Adolescent (BASC-3 TRS Adolescent)
- Behavioral Assessment System for Children, 3rd ed, Teacher Rating Scales, Child (BASC-3 TRS Child)
- Behavioral Assessment System for Children, 3rd ed, Teacher Rating Scales, Preschool (BASC-3 TRS Preschool)
- Bracken School Readiness Assessment, 4th ed (BSRA-4)
- Brown Executive Function/Attention Scales, Parent Report (Brown EF/A Parent)
- Brown Executive Function/Attention Scales, Self-Report (Brown EF/A Self)
- Brown Executive Function/Attention Scales, Teacher Report (Brown EF/A Teacher)
- California Verbal Learning Test, Child ed (CVLT-C)
- Childhood Autism Rating Scale, 2nd ed (CARS-2)
- Childhood Autism Rating Scale, 2nd ed, High-Functioning Version (CARS-2 HF)
- Childhood Autism Rating Scale, 2nd ed, Questionnaire for Parents or Caregivers (CARS-2 QPC)
- Children's Memory Scale, 3rd ed (CMS-3)
- Clinical Evaluation of Language Fundamentals Preschool, 3rd ed (CELF Preschool-3)
- Clinical Evaluation of Language Fundamentals, 5th ed, Ages 5-8 (CELF-5)
- Clinical Evaluation of Language Fundamentals, 5th ed, Ages 9-21 (CELF-5)
- Comprehensive Executive Function Inventory, Parent Report (CEFI Parent)
- Comprehensive Executive Function Inventory, Self-Report (CEFI Self)
- Comprehensive Executive Function Inventory, Teacher Report (CEFI Teacher)
- Comprehensive Executive Function Inventory, Youth Report (CEFI Youth)
- Conners' Rating Scale, 4th ed, Parent (Conners-4 Parent)
- Conners' Rating Scale, 4th ed, Self-Report (Conners-4 Self)

- Conners' Rating Scale, 4th ed, Teacher (Conners-4 Teacher)
- Delis-Kaplan Executive Function System (D-KEFS):
  - Color-Word Interference Test
  - Trail Making Test
- Grooved Pegboard Test
- Kaufman Test of Educational Achievement, 3rd ed, Form A (KTEA-3 Form A)
- Kaufman Test of Educational Achievement, 3rd ed, Form B (KTEA-3 Form B)
- NEPSY-II Developmental Neuropsychological Battery
- PROMIS Sleep Assessments Pediatric Parent Proxy
- Rating Scale of Impairment (RSI)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form A (RBANS)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form B (RBANS)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form C (RBANS)
- Repeatable Battery for the Assessment of Neuropsychological Status, Form D (RBANS)
- Rey-Osterrieth Complex Figure Test (ROCFT)
- Test of Memory Malingering (TOMM)
- Trail Making Test (TMT)
- Wechsler Adult Intelligence Scale, 5th ed (WAIS-5)
- Wechsler Adult Intelligence Scale, 4th ed (WAIS-IV)
- Wechsler Abbreviated Scale of Intelligence, 2nd ed (WASI-2)
- Wechsler Individual Achievement Test, 4th ed (WIAT-4)
- Wechsler Individual Achievement Test, 4th ed (WIAT-4): Word Reading, Reading Comprehension, Pseudoword Decoding, Orthographic Fluency, Decoding Fluency
- Wechsler Intelligence Scale for Children, 5th ed (WISC-V)
- Wechsler Preschool and Primary Scale of Intelligence, 4th ed, Ages 2-3 (WPPSI-IV)
- Wechsler Preschool and Primary Scale of Intelligence, 4th ed, Ages 4-7 (WPPSI-IV)
- Personality Assessment Inventory, Adolescent (PAI-A)
- Wide Range Achievement Test, 5th ed (WRAT-5)
- Wide Range Achievement Test, 5th ed, Blue Form (WRAT-5): Word Reading
- Wide Range Achievement Test, 5th ed, Green Form (WRAT-5): Word Reading
- NIH Executive Abilities–Measures and Instruments for Neurobehavioral Evaluation and Research (NIH EXAMINER):
  - Behavioral Rating Scale
  - Word Fluency
  - Unstructured Task
- Personality Assessment Inventory, Adolescent (PAI Adolescent)

NEUROBEHAVIORAL STATUS EXAM

Reason for Referral

Biggie Smalls is a 20-year-old, rightright-handed research assistant with 10 years years of education, including a B.A. in Rapping from the University of Brooklyn. He was referred in order to determine the nature and extent of neurocognitive sequelae emerging from a history of attention-deficit/hyperactivity disorder (ADHD).

The purpose of the current evaluation is ADHD, anxiety, and depression. This report is based on a review of available medical records and information gathered across multiple days of evaluation. Treatment planning and plans for test accommodations were discussed with Biggie during the feedback visit on the final day of the examination.

Background

The following information was obtained during an interview with Biggie and from review of available medical records. Biggie has been doing well in his classes since starting law school and has never failed. However, issues have begun to arise that he has been unable to avoid, including being easily distracted, restlessness, constantly fidgeting, procrastination, and variable attention. He suspects having ADHD and has always struggled with aspects of it. Biggie's mother tried to get his evaluated and tested when he was younger, but was never able to do so because his school at the time did not agree that there were major concerns. He has noticed increasing difficulty initiating tasks, especially when it comes to writing long research papers, and has been procrastinating more and more. Biggie has read up on ADHD and believes he may have it, but has been able to hide it from others, as he has "gotten good at pretending to pay attention." He seeks further assessment and evaluation to identify any underlying neurocognitive factors influencing his academic motivations and performance.

Cognitive complaints: sustained attention, working memory, and organization.

Relevant History

Past Neuropsychological Test Results

Patient denied having prior testing.

Birth/Early Development

- Normal pregnancy, birth, and delivery.
- Developmental milestones achieved on time.

Medical History

- **Current**: Consequat ad est amet deserunt dolor amet cillum nisi irure sit consequat officia do..
- **Family**: Irure anim qui deserunt eu culpa aliqua ea consequat deserunt..
- **Medications**: None.
- **Appetite/Weight**: Stable with no significant changes recently.
- **Sleep**: Normal, no changes.
- **Neurological Injury**: Voluptate magna do id veniam id laborum in qui magna sint ad cillum commodo.
- **Psychiatric**: ADHD, anxiety, and depression.

Emotional/Behavioral/Social/Personality

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Educational History

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Occupational History

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Cultural/Social Context

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Mental Status/Behavioral Observations

- **Attention/Orientation**: Orientation to person, place, time, and situation was intact.
- **Appearance**: Appropriate grooming and dress for context.
- **Behavior/Attitude**: Cooperative, engaged. No gross behavioral apathy or disinhibition observed.
- **Speech/Language**: Fluent and normal in rate, volume, and prosody.
- **Mood/Affect**: Neutral, range was full and appropriate.
- **Sensory/Motor**: Performance was not limited by any obvious sensory or motor difficulties.
- **Cognitive Process**: Coherent and goal directed.
- **Effort/Validity**: Normal; TOMM Trial 1 = 48/50, TOMM Trial 2 = 50/50, RDS = >6, DCT = 4.3.

NEUROCOGNITIVE FINDINGS

General Cognitive Ability

The patient exhibited Above Average verbal reasoning and comprehension, supporting effective communication and understanding of complex instructions in academic, professional, and social contexts. However, Below Average processing speed and attention to detail may hinder efficiency in tasks requiring rapid information sorting or sustained focus, potentially impacting productivity in fast-paced or detail-oriented environments. While executive functioning, such as organizational planning and problem-solving, was within the Average range, suggesting capacity for structured task management, challenges may arise in adapting to time-sensitive or multitasking demands. These patterns could affect performance in roles requiring quick decision-making or handling high-volume data, with compensatory strategies likely beneficial for enhancing functional outcomes in daily life.

Table 1: General Cognitive Ability Scores

	SCORE	‰ RANK	RANGE
RBANS[1]			
RBANS Total Index	103	58	Average
WISC-V[1]			
Verbal Comprehension (VCI)	118	88	High Average
Visual Spatial (VSI)	89	23	Low Average
Fluid Reasoning (FRI)	97	42	Average
Working Memory (WMI)	88	21	Low Average
Processing Speed (PSI)	77	6	Below Average
Full Scale IQ (FSIQ)	96	39	Average
Nonverbal (NVI)	87	19	Low Average
General Ability (GAI)	104	61	Average
Cognitive Proficiency (CPI)	79	8	Below Average

[1] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

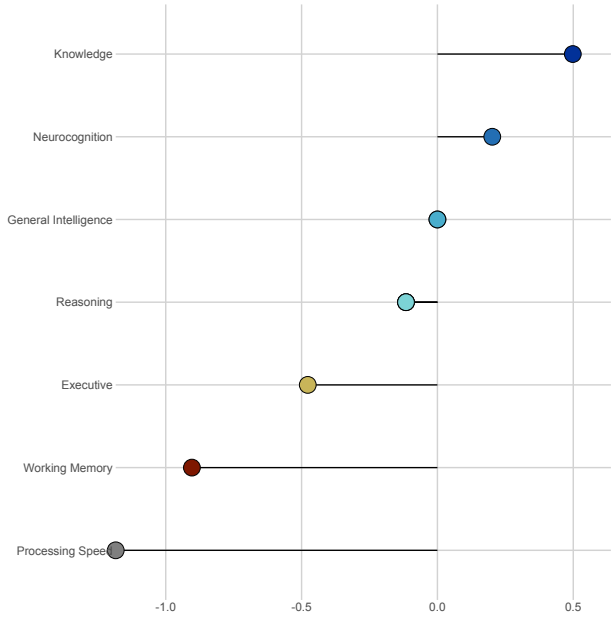

Figure 1: Premorbid Ability is an estimate of an individual's intellectual functioning prior to known or suspected onset of brain disease or dysfunction. General Ability is the overall skill to reason, solve problems, and gain useful knowledge. Crystallized Knowledge involves understanding the world through language and reasoning. Fluid Reasoning is the logical analysis and solution of new problems, identifying underlying patterns, and applying logic.

Table 2: General Cognitive Ability Scores

	SCORE	‰ RANK	RANGE
RBANS[1]			
RBANS Total Index	103	58	Average
WISC-V[1]			
Verbal Comprehension (VCI)	118	88	High Average
Visual Spatial (VSI)	89	23	Low Average
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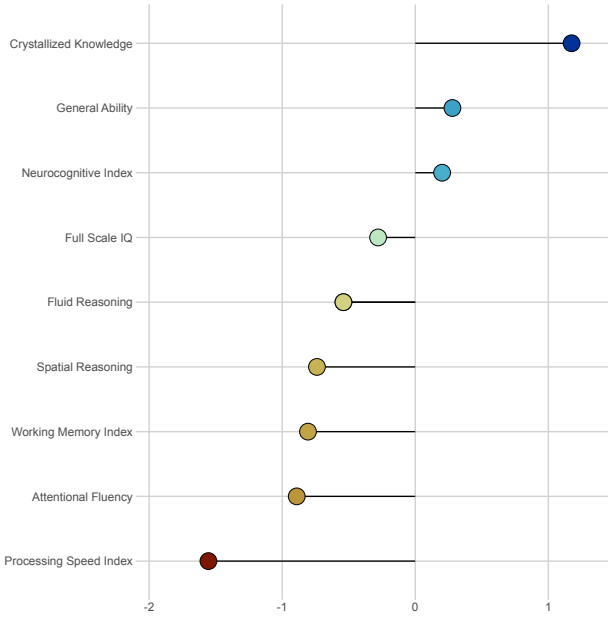

Figure 2: Premorbid Ability is an estimate of an individual's intellectual functioning prior to known or suspected onset of brain disease or dysfunction. General Ability is the overall skill to reason, solve problems, and gain useful knowledge. Crystallized Knowledge involves understanding the world through language and reasoning. Fluid Reasoning is the logical analysis and solution of new problems, identifying underlying patterns, and applying logic.

Academic Skills

The provided target domain text is empty, so no academic performance summary can be generated. Please provide neurocognitive assessment results or relevant clinical findings to create a summary based on the specified instructions.

Table 3: Academic Skills Scores

	SCORE	‰ RANK	RANGE
WIAT-4[1]			
Word Reading	82	12	Low Average
Spelling	84	14	Low Average
Essay Composition	97	42	Average
Numerical Operations	82	12	Low Average

[1] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

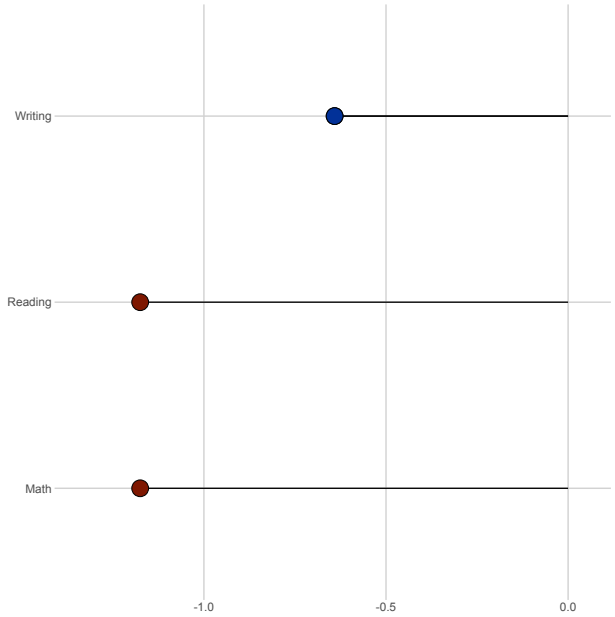

Figure 3: Reading, writing, and math are the three main academic skills assessed on exam. Reading ability consists of three interrelated abilities: decoding, comprehension, and fluency. Writing ability can be described in terms of spelling, grammar, expression of ideas, and writing fluency. Math ability can be described in terms of calculation skills, applied problem solving, and math fluency.

Table 4: Academic Skills Scores

	SCORE	‰ RANK	RANGE
WIAT-4[1]			
Word Reading	82	12	Low Average
Spelling	84	14	Low Average
Essay Composition	97	42	Average
Numerical Operations	82	12	Low Average

[1] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

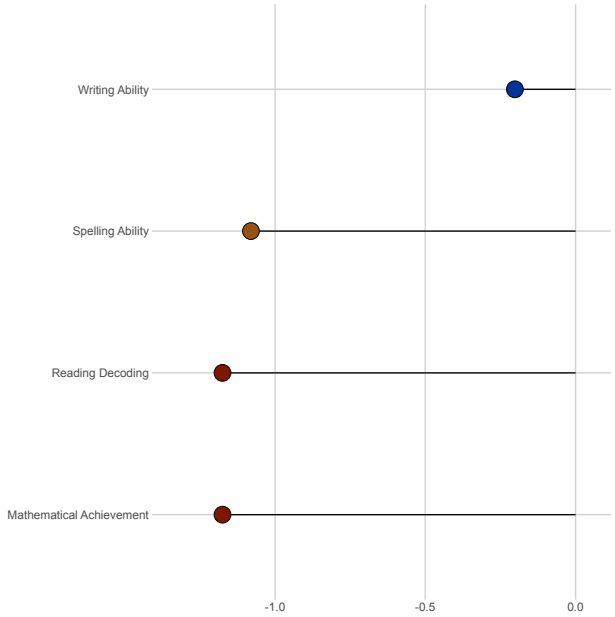

Figure 4: Reading, writing, and math are the three main academic skills assessed on exam. Reading ability consists of three interrelated abilities: decoding, comprehension, and fluency. Writing ability can be described in terms of spelling, grammar, expression of ideas, and writing fluency. Math ability can be described in terms of calculation skills, applied problem solving, and math fluency.

Verbal/Language

The provided target domain text contains no assessment data or findings, making it impossible to construct a meaningful clinical summary of the patient's verbal/language performance. Without specific neurocognitive test results or performance metrics, interpretation of real-world functional implications cannot be undertaken. Please provide relevant assessment details to enable a comprehensive summary.

Table 5: Verbal/Language Scores

	SCORE	‰ RANK	RANGE
D-KEFS Color-Word Interference			
CWI Color Naming	8	25	Average
CWI Word Reading	8	25	Average
RBANS[1,2]			
Picture Naming	–	37	Average
Semantic Fluency	13	84	High Average
Language Index	109	73	Average
WISC-V[1]			
Similarities	14	91	Above Average
Vocabulary	13	84	High Average
Comprehension	8	25	Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

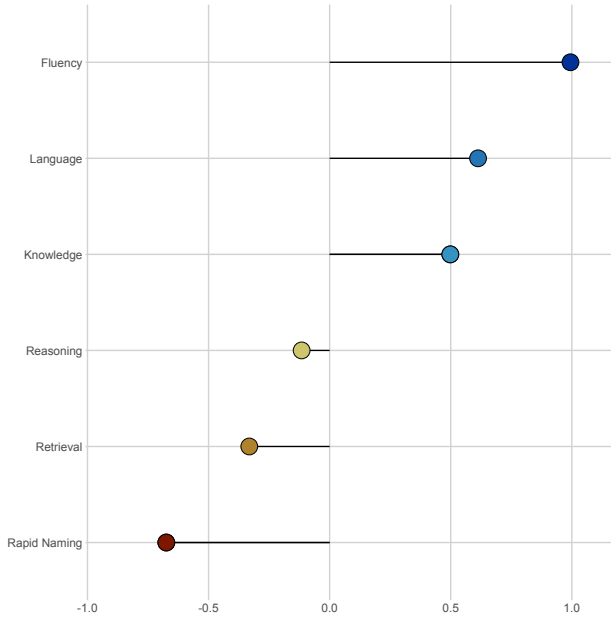

Figure 5: Verbal and language functioning refers to the ability to access and apply acquired word knowledge, to verbalize meaningful concepts, to understand complex multistep instructions, to think about verbal information, and to express oneself using words.

Table 6: Verbal/Language Scores

	SCORE	‰ RANK	RANGE
D-KEFS Color-Word Interference			
CWI Color Naming	8	25	Average
CWI Word Reading	8	25	Average
RBANS[1,2]			
Picture Naming	–	37	Average
Semantic Fluency	13	84	High Average
Language Index	109	73	Average
WISC-V[1]			
Similarities	14	91	Above Average
Vocabulary	13	84	High Average
Comprehension	8	25	Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

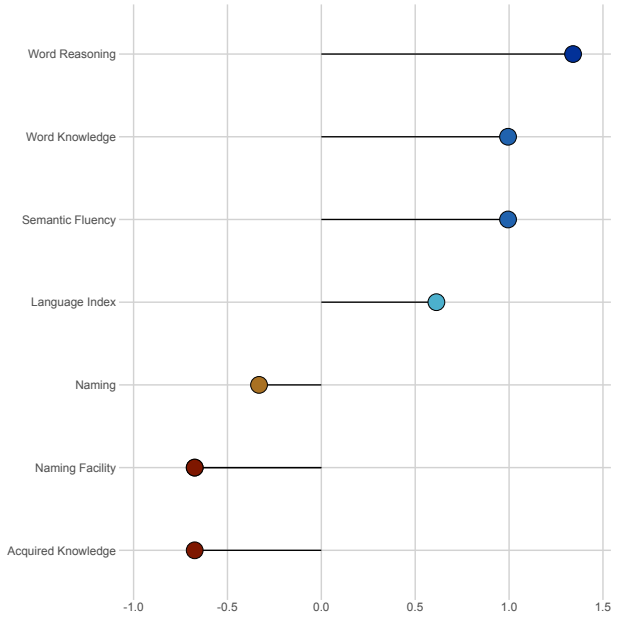

Figure 6: Verbal and language functioning refers to the ability to access and apply acquired word knowledge, to verbalize meaningful concepts, to understand complex multistep instructions, to think about verbal information, and to express oneself using words.

Visual Perception/Construction

The patient demonstrated Below Average proficiency in spatial orientation and visual construction, which may impact their ability to navigate complex environments or perform tasks requiring visual-motor coordination, such as writing or assembling objects. Strengths in pattern recognition and visual interpretation suggest potential for success in structured academic settings, particularly with tasks involving logical sequencing or symbolic reasoning. Challenges in spatial problem-solving may require accommodations in environments demanding precise visual-spatial skills, such as map reading or organizing multi-step projects. These findings highlight the need for strategies to support visual-spatial processing while leveraging existing strengths in pattern recognition to enhance functional independence in daily activities.

Table 7: Visual Perception/Construction Scores

	SCORE	‰ RANK	RANGE
RBANS[1,2]			
Figure Copy	7	15	Low Average
Line Orientation	–	13	Low Average
Visuospatial/Constructional Index	75	5	Below Average
WISC-V[1]			
Block Design	7	16	Low Average
Visual Puzzles	9	37	Average
Matrix Reasoning	9	37	Average
Figure Weights	10	50	Average
Picture Concepts	10	50	Average
Block Design No Time Bonus	7	16	Low Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

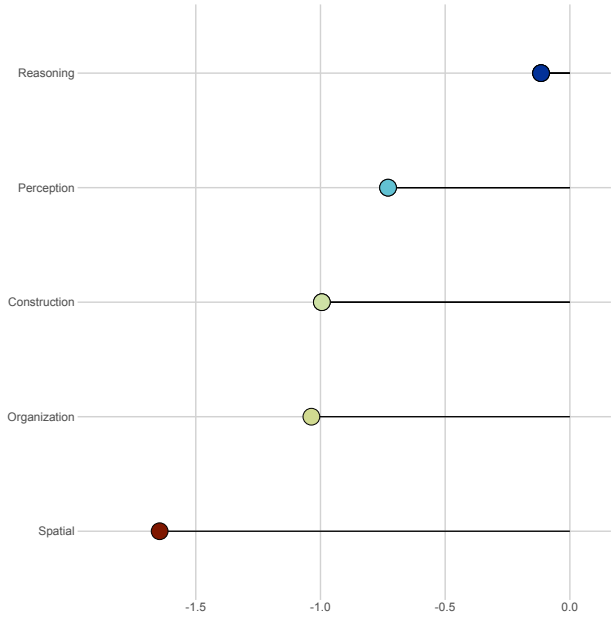

Figure 7: Perception, construction, and visuospatial processing refer to abilities such as mentally visualizing how objects should look from different angles, visualizing how to put objects together so that they fit correctly, and being able to accurately and efficiently copy and/or reproduce visual-spatial information onto paper.

Table 8: Visual Perception/Construction Scores

	SCORE	‰ RANK	RANGE
RBANS[1,2]			
Figure Copy	7	15	Low Average
Line Orientation	–	13	Low Average
Visuospatial/Constructional Index	75	5	Below Average
WISC-V[1]			
Block Design	7	16	Low Average
Visual Puzzles	9	37	Average
Matrix Reasoning	9	37	Average
Figure Weights	10	50	Average
Picture Concepts	10	50	Average
Block Design No Time Bonus	7	16	Low Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

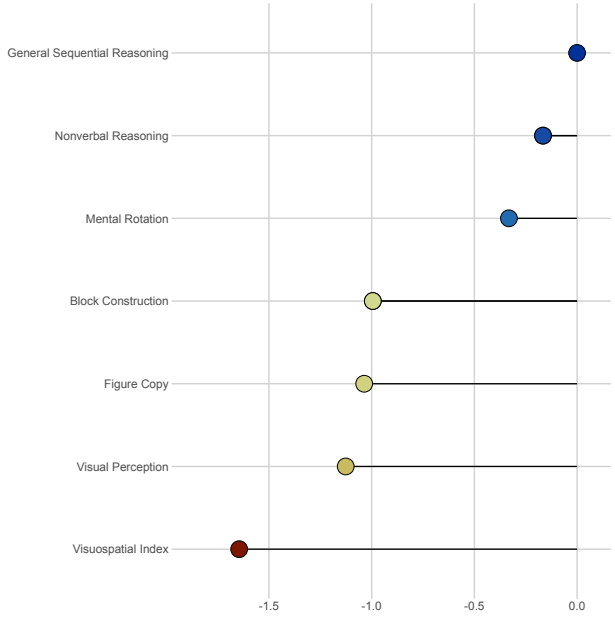

Figure 8: Perception, construction, and visuospatial processing refer to abilities such as mentally visualizing how objects should look from different angles, visualizing how to put objects together so that they fit correctly, and being able to accurately and efficiently copy and/or reproduce visual-spatial information onto paper.

Memory

The provided target domain text contains no assessment data or findings, making it impossible to generate a clinical summary in accordance with the specified format and content requirements. Please provide relevant neurocognitive assessment results or performance descriptors to enable a meaningful analysis of the patient's functional capabilities.

Table 9: Memory Scores

	SCORE	‰ RANK	RANGE
RBANS[1,2]			
List Learning	13	84	High Average
Story Memory	16	97	Above Average
List Recall	–	37	Average
List Recognition	–	63	Average
Story Recall	16	97	Above Average
Figure Recall	10	50	Average
Immediate Memory Index	126	96	Above Average
Delayed Memory Index	89	23	Low Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

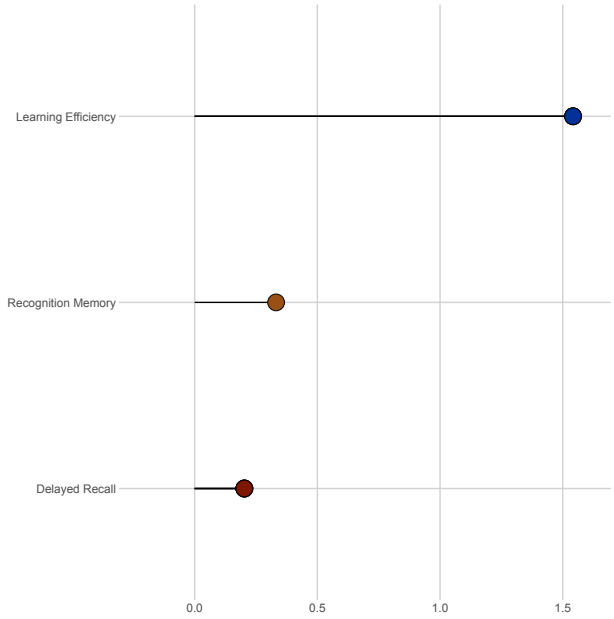

Figure 9: Learning and memory refer to the rate and ease with which new information (e.g., facts, stories, lists, faces, names) can be encoded, stored, and later recalled from long-term memory.

Table 10: Memory Scores

	SCORE	‰ RANK	RANGE
RBANS[1,2]			
List Learning	13	84	High Average
Story Memory	16	97	Above Average
List Recall	–	37	Average
List Recognition	–	63	Average
Story Recall	16	97	Above Average
Figure Recall	10	50	Average
Immediate Memory Index	126	96	Above Average
Delayed Memory Index	89	23	Low Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

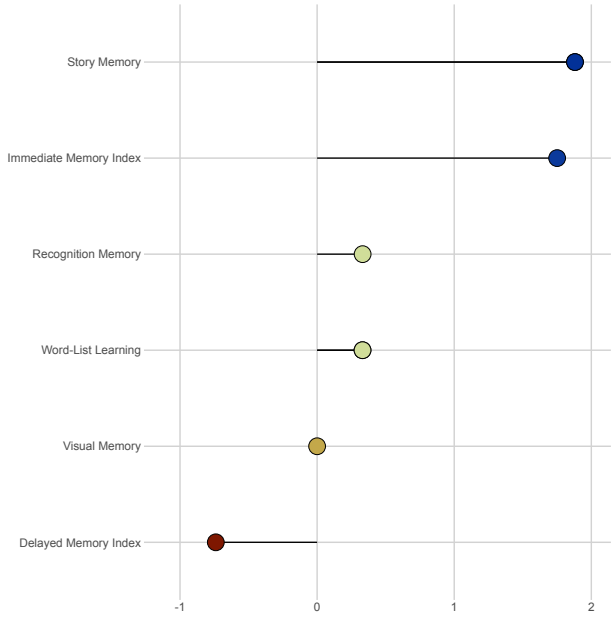

Figure 10: Learning and memory refer to the rate and ease with which new information (e.g., facts, stories, lists, faces, names) can be encoded, stored, and later recalled from long-term memory.

Attention/Executive

The patient exhibited Below Average capacity to maintain attention during extended tasks, which may hinder completion of complex work or study assignments without frequent breaks. Executive functioning revealed mixed patterns, with Above Average ability to plan and organize multi-step projects, yet Below Average flexibility in adapting to shifting priorities or unexpected challenges. These findings suggest strengths in structured, goal-oriented activities but potential difficulties with spontaneous problem-solving or managing competing demands in dynamic environments. The profile highlights the need for strategies to support sustained attention during prolonged tasks while utilizing organizational strengths to improve efficiency in routine settings.

Table 11: Attention/Executive Scores

	SCORE	‰ RANK	RANGE
D-KEFS Color-Word Interference			
CWI Inhibition	9	36	Average
CWI Inhibition/Switching	11	63	Average
CWI Color Naming Total Errors	–	15	Low Average
CWI Word Reading Total Errors	–	100	Exceptionally High
CWI Word Reading Total Errors	7	15	Low Average
CWI Inhibition/Switching Total Errors	5	4	Below Average
RBANS[1,2]			
RBANS Digit Span	11	63	Average
RBANS Coding	14	90	High Average
Attention Index	116	86	High Average
Trail Making Test[3]			
TMT, Part A	9	–	Exceptionally Low
TMT, Part B	30	2	Below Average
WISC-V[1]			
Digit Span	7	16	Low Average
Picture Span	9	37	Average
Coding	6	9	Low Average
Symbol Search	6	9	Low Average
Cancellation	9	37	Average
Digit Span Forward	9	37	Average
Digit Span Backward	9	37	Average
Digit Span Sequencing	4	2	Below Average
Cancellation Random	9	37	Average
Cancellation Structured	9	37	Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

[3] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

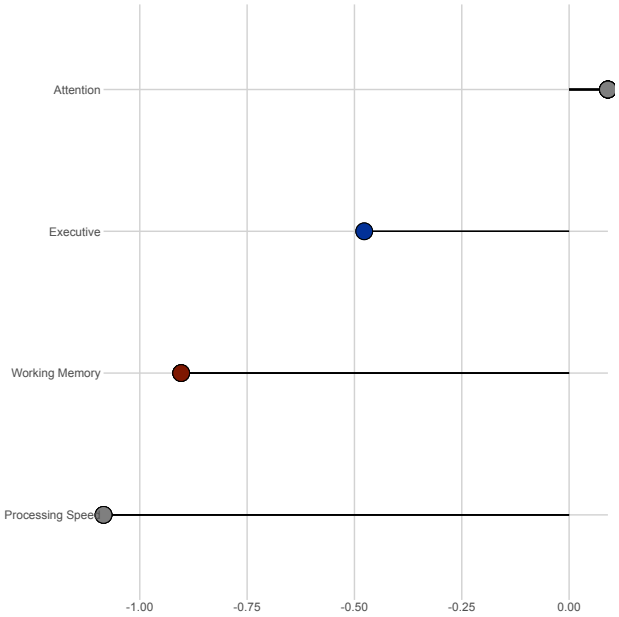

Figure 11: Attentional and executive functions underlie most, if not all, domains of cognitive performance. These are behaviors and skills that allow individuals to successfully carry-out instrumental and social activities, academic work, engage with others effectively, problem solve, and success- fully interact with the environment to get needs met.

Table 12: Attention/Executive Scores

	SCORE	‰ RANK	RANGE
D-KEFS Color-Word Interference			
CWI Inhibition	9	36	Average
CWI Inhibition/Switching	11	63	Average
CWI Color Naming Total Errors	–	15	Low Average
CWI Word Reading Total Errors	–	100	Exceptionally High
CWI Word Reading Total Errors	7	15	Low Average
CWI Inhibition/Switching Total Errors	5	4	Below Average
RBANS[1,2]			
RBANS Digit Span	11	63	Average
RBANS Coding	14	90	High Average
Attention Index	116	86	High Average
Trail Making Test[3]			
TMT, Part A	9	–	Exceptionally Low
TMT, Part B	30	2	Below Average
WISC-V[1]			
Digit Span	7	16	Low Average
Picture Span	9	37	Average
Coding	6	9	Low Average
Symbol Search	6	9	Low Average
Cancellation	9	37	Average
Digit Span Forward	9	37	Average
Digit Span Backward	9	37	Average
Digit Span Sequencing	4	2	Below Average
Cancellation Random	9	37	Average
Cancellation Structured	9	37	Average

[1] Scaled score: Mean = 10 [50th‰], SD ± 3 [16th‰, 84th‰]

[2] Standard score: Mean = 100 [50th‰], SD ± 15 [16th‰, 84th‰]

[3] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

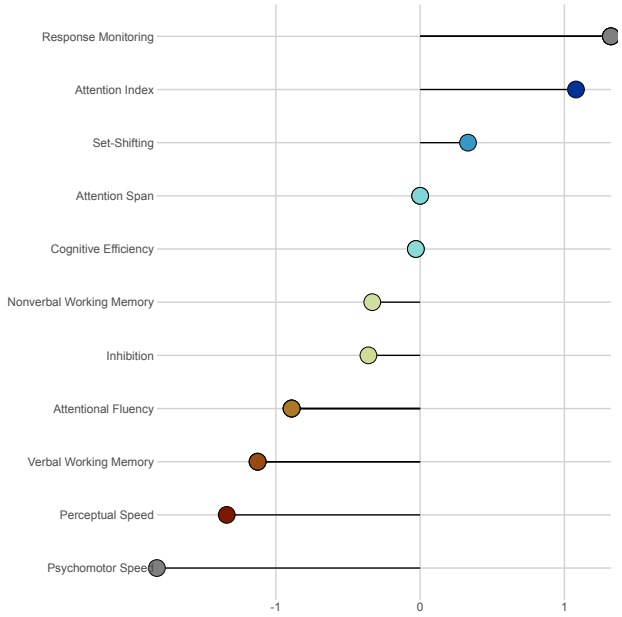

Figure 12: Attentional and executive functions underlie most, if not all, domains of cognitive performance. These are behaviors and skills that allow individuals to successfully carry-out instrumental and social activities, academic work, engage with others effectively, problem solve, and success- fully interact with the environment to get needs met.

Motor

The patient exhibited Above Average fine motor skills, enabling effective performance of tasks requiring precision such as writing, crafting, or using small tools, which supports independence in activities like keyboarding or detailed manual work. However, Below Average gross motor coordination may limit bilateral coordination and balance, potentially affecting participation in activities requiring physical effort, such as climbing stairs, sports, or manual labor. These findings suggest strengths in tasks emphasizing hand dexterity, while challenges in larger-movement tasks may require adaptive strategies or environmental modifications to optimize functional outcomes in daily settings.

Table 13: Motor Scores

	SCORE	‰ RANK	RANGE
Grooved Pegboard[1]			
Dominant Hand Time	17	–	Exceptionally Low
Nondominant Hand Time	22	1	Exceptionally Low

[1] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

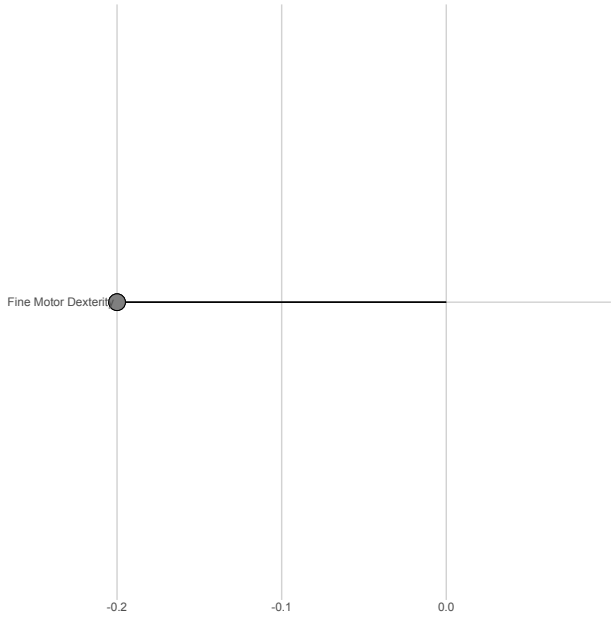

Figure 13: Sensorimotor tasks refer to the capacity to control hand movements quickly, smoothly, and with adequate precision, which are required to engage in activities such as writing and drawing.

Table 14: Motor Scores

	SCORE	‰ RANK	RANGE
Grooved Pegboard[1]			
Dominant Hand Time	17	–	Exceptionally Low
Nondominant Hand Time	22	1	Exceptionally Low

[1] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

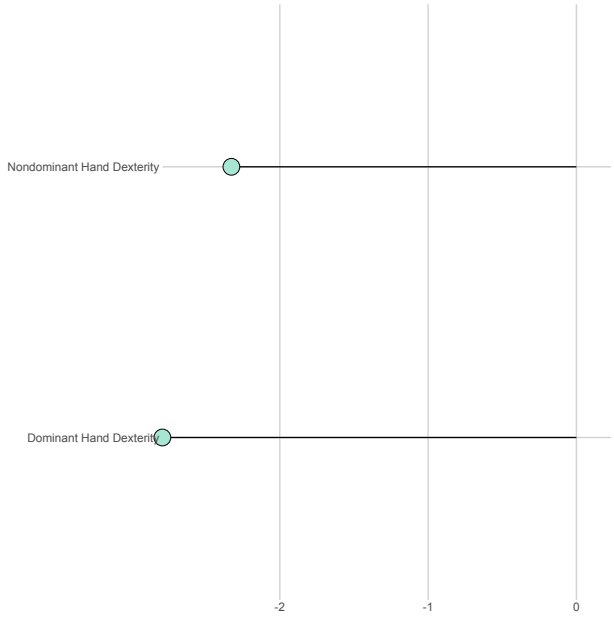

Figure 14: Sensorimotor tasks refer to the capacity to control hand movements quickly, smoothly, and with adequate precision, which are required to engage in activities such as writing and drawing.

Emotional/Behavioral/Social/Personality

The provided target domain text is empty, so no summary can be generated. Please supply the patient's self-reported assessment data (e.g., difficulties with emotional regulation, behavioral patterns, social interactions, or personality traits) to create a clinical summary based on the specified guidelines.

Table 15: Emotional/Behavioral/Social/Personality Scores

	SCORE	‰ RANK	RANGE
BASC-3 PRS Adolescent[T]			
Externalizing Problems	64	91	Above Average
Internalizing Problems	46	40	Average
Behavioral Symptoms Index	65	92	Above Average
Adaptive Skills	37	12	Low Average
Hyperactivity	58	83	High Average
Aggression	61	90	High Average
Conduct Problems	70	95	Above Average
Anxiety	43	27	Average
Depression	55	79	High Average
Somatization	41	15	Low Average
Atypicality	69	94	Above Average
Withdrawal	65	91	Above Average
Attention Problems	66	92	Above Average
Adaptability	41	19	Low Average
Social Skills	34	8	Below Average
Leadership	32	4	Below Average
Activities of Daily Living	45	29	Average
Functional Communication	42	21	Low Average
PAI Adolescent[T]			
Somatic Complaints	40	15	Low Average
Conversion	43	24	Low Average
Somatization	40	15	Low Average
Health Concerns	42	21	Low Average
Anxiety	36	8	Below Average
Cognitive (A)	39	13	Low Average
Affective (A)	36	8	Below Average
Physiological (A)	39	13	Low Average
Anxiety-Related Disorders	49	46	Average
Obsessive-Compulsive	56	72	Average
Phobias	45	30	Average
Traumatic Stress	47	38	Average
Depression	39	13	Low Average
Cognitive (D)	40	15	Low Average
Affective (D)	47	38	Average
Physiological (D)	35	6	Below Average
Mania	44	27	Average
Activity Level	38	11	Low Average
Grandiosity	57	75	High Average
Irritability	40	15	Low Average
Paranoia	39	13	Low Average
Hypervigilance	43	24	Low Average
Persecution	46	34	Average
Resentment	37	9	Low Average
Schizophrenia	35	6	Below Average
Psychotic Experiences	37	9	Low Average
Social Detachment	41	18	Low Average
Thought Disorder	39	13	Low Average
Borderline Features	41	18	Low Average
Affective Instability	38	11	Low Average
Identity Problems	41	18	Low Average
Negative Relationships	49	46	Average
Self-Harm	44	27	Average
Antisocial Features	50	50	Average
Antisocial Behaviors	53	61	Average
Egocentricity	52	57	Average
Stimulus-Seeking	46	34	Average
Aggression	40	15	Low Average
Aggressive Attitude	34	5	Below Average
Verbal Aggression	44	27	Average
Physical Aggression	47	38	Average
Alcohol Problems	52	57	Average
Drug Problems	52	57	Average
Suicidal Ideation	42	21	Low Average
Stress	42	21	Low Average
Nonsupport	41	18	Low Average
Treatment Rejection	48	42	Average
Dominance	47	38	Average
Warmth	52	57	Average

[T] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

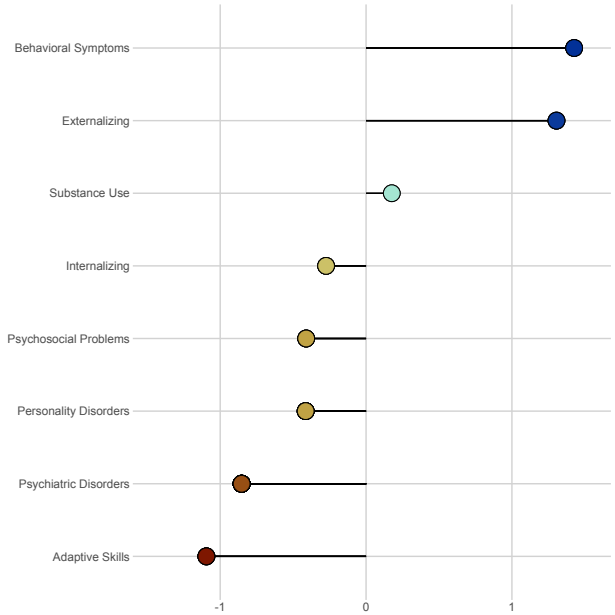

Figure 15: Mood, Behavioral, and Social-Emotional Reports. Self-reports of behavioral, emotional, and social difficulties.

Table 16: Emotional/Behavioral/Social/Personality Scores

	SCORE	‰ RANK	RANGE
BASC-3 PRS Adolescent[T]			
Externalizing Problems	64	91	Above Average
Internalizing Problems	46	40	Average
Behavioral Symptoms Index	65	92	Above Average
Adaptive Skills	37	12	Low Average
Hyperactivity	58	83	High Average
Aggression	61	90	High Average
Conduct Problems	70	95	Above Average
Anxiety	43	27	Average
Depression	55	79	High Average
Somatization	41	15	Low Average
Atypicality	69	94	Above Average
Withdrawal	65	91	Above Average
Attention Problems	66	92	Above Average
Adaptability	41	19	Low Average
Social Skills	34	8	Below Average
Leadership	32	4	Below Average
Activities of Daily Living	45	29	Average
Functional Communication	42	21	Low Average
PAI Adolescent[T]			
Somatic Complaints	40	15	Low Average
Conversion	43	24	Low Average
Somatization	40	15	Low Average
Health Concerns	42	21	Low Average
Anxiety	36	8	Below Average
Cognitive (A)	39	13	Low Average
Affective (A)	36	8	Below Average
Physiological (A)	39	13	Low Average
Anxiety-Related Disorders	49	46	Average
Obsessive-Compulsive	56	72	Average
Phobias	45	30	Average
Traumatic Stress	47	38	Average
Depression	39	13	Low Average
Cognitive (D)	40	15	Low Average
Affective (D)	47	38	Average
Physiological (D)	35	6	Below Average
Mania	44	27	Average
Activity Level	38	11	Low Average
Grandiosity	57	75	High Average
Irritability	40	15	Low Average
Paranoia	39	13	Low Average
Hypervigilance	43	24	Low Average
Persecution	46	34	Average
Resentment	37	9	Low Average
Schizophrenia	35	6	Below Average
Psychotic Experiences	37	9	Low Average
Social Detachment	41	18	Low Average
Thought Disorder	39	13	Low Average
Borderline Features	41	18	Low Average
Affective Instability	38	11	Low Average
Identity Problems	41	18	Low Average
Negative Relationships	49	46	Average
Self-Harm	44	27	Average
Antisocial Features	50	50	Average
Antisocial Behaviors	53	61	Average
Egocentricity	52	57	Average
Stimulus-Seeking	46	34	Average
Aggression	40	15	Low Average
Aggressive Attitude	34	5	Below Average
Verbal Aggression	44	27	Average
Physical Aggression	47	38	Average
Alcohol Problems	52	57	Average
Drug Problems	52	57	Average
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Treatment Rejection	48	42	Average
Dominance	47	38	Average
Warmth	52	57	Average

[T] T score: Mean = 50 [50th‰], SD ± 10 [16th‰, 84th‰]

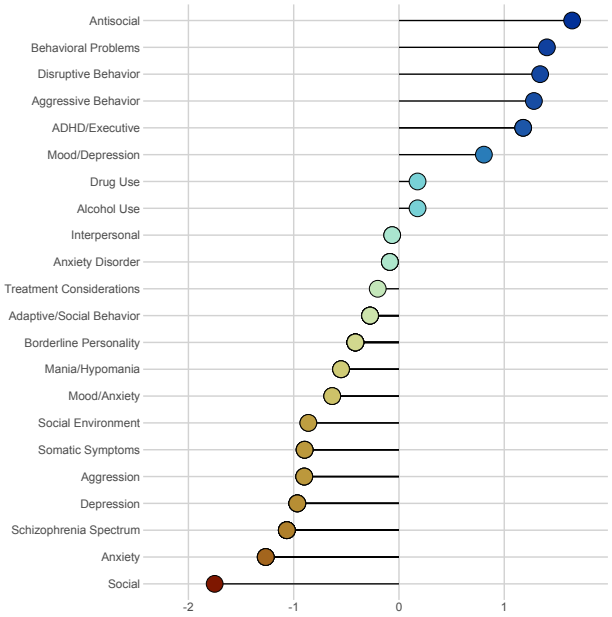

Figure 16: Mood, Behavioral, and Social-Emotional Reports. Self-reports of behavioral, emotional, and social difficulties.

SUMMARY/IMPRESSION

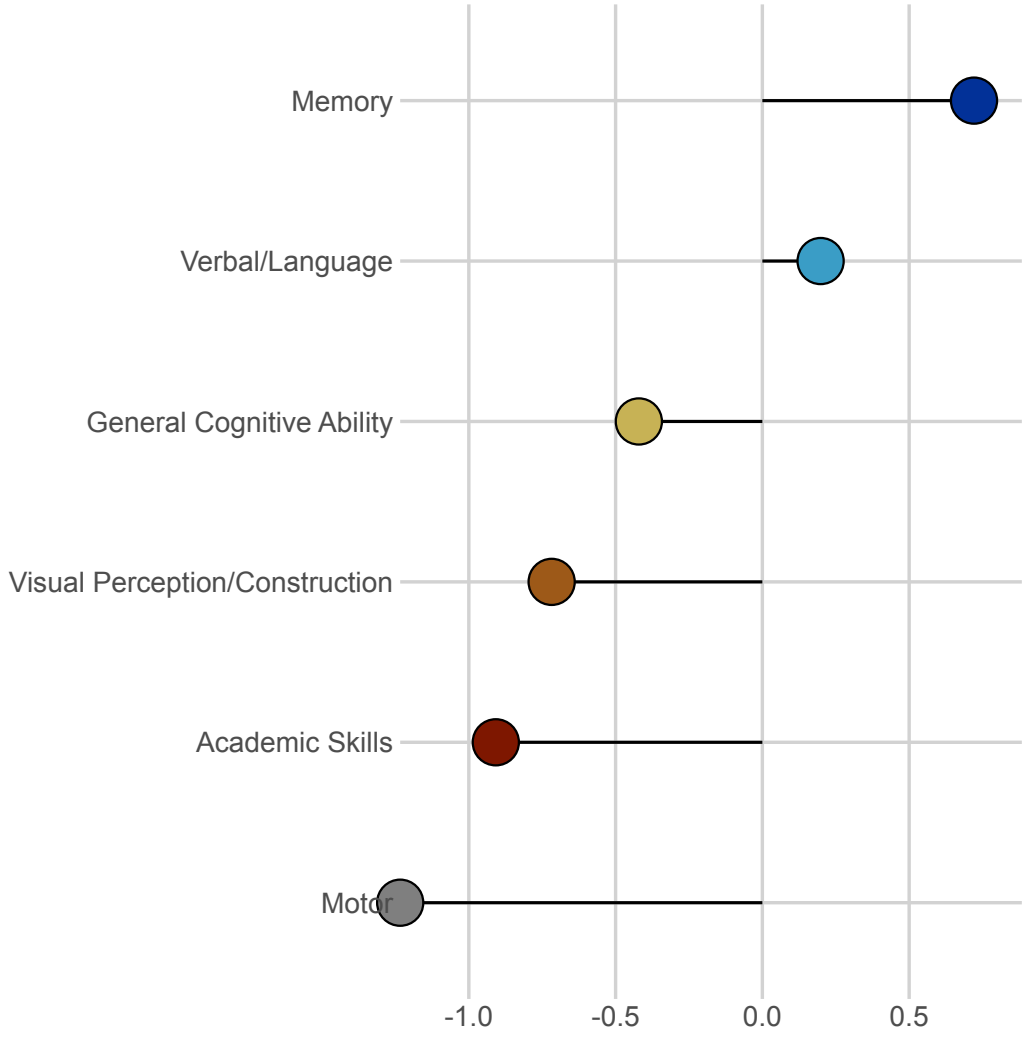

Figure 17: Overall neurocognitive function subdomain plots of the patient's strengths and weaknesses. *Note: z*-scores have a mean of 0 and a standard deviation of 1.

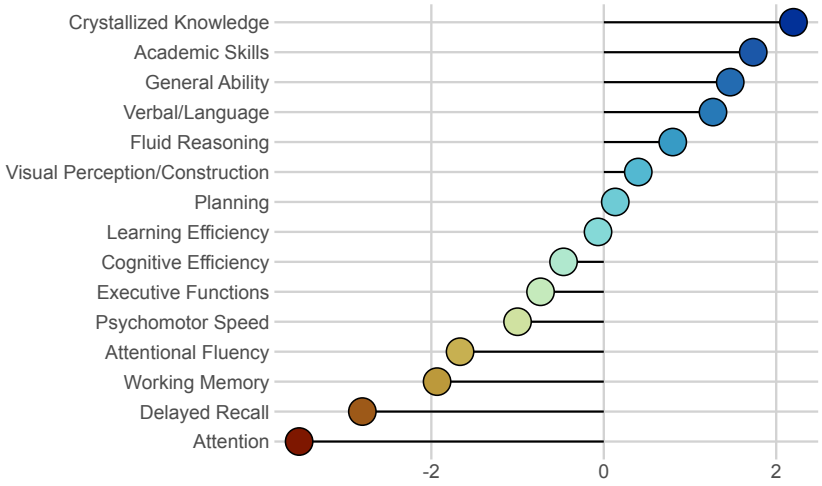

Figure 18: Plots depicting the patient's strengths and weaknesses across neurocognitive function subdomains. Note: z-scores are standardized with a mean of 0 and a standard deviation of 1.

Overall Evaluation Interpretation

Biggie Smalls is a 20-year-old right-handed male with a history of ADHD, anxiety, and depression who was referred for neuropsychological testing as part of a comprehensive work-up for attention-deficit/hyperactivity disorder. General cognitive ability is well within normal limits, and there is no evidence of decline from premorbid estimates. No deficits were detected in the domains of attention, processing speed, motor functioning, or visuospatial skills. Although many aspects of executive functioning, language functioning, and memory were within normal limits, he demonstrated mildly inefficient problem solving and hypothesis testing, weaknesses in word retrieval, and inefficiency in new learning of verbal information. There is no evidence of a mood disorder at this time.

In conclusion, the cognitive profile is ...

Diagnostic Impression

- 294.11 (F02.81) Major Neurocognitive Disorder Due to Another Medical Condition, Moderate, With behavioral disturbance
- 8A68.4 Generalized tonic-clonic seizure
- V61.10 (Z63.0) Relational Problems
- DSM-5/ICD-10 Codes

Mental Health Diversion: Contextual Analysis and Interpretation

1. Does the defendant suffer from any mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)?

Yes, the defendant meets the criteria for multiple mental disorders as defined by DSM-5.

2. Were any mental disorders a motivating, causal, or contributing factor to the defendant's involvement in the commission of the offense?

Yes, causal.

3. If any mental disorders were significant factors in the commission of the offense, would the defendant's symptoms of those mental disorders respond to treatment?

Yes. The defendant's symptoms related to cognitive impairment and mood problems would respond well to treatment.

4. Does the defendant agree to comply with treatment as a condition of diversion?

Yes, the defendant agreed to comply with treatment as a condition of diversion.

5. Would the defendant pose an unreasonable risk of danger to public safety (under the meaning of California Penal Code 1001.36), if treated in the community?

The defendant would not pose "an unreasonable risk of danger to public safety" under the meaning of California Penal Code 1001.36, if treated in the community.

RECOMMENDATIONS

Recommendations for Medical/Healthcare

- Biggie should receive interventions to enhance concentration, manage anxiety, and improve emotional understanding. This includes social skills training, psychoeducational interventions for self-image improvement, and monitoring for signs of internalization or externalization of problems.
- **Cognitive Behavioral Therapy (CBT):** To develop strategies for improving executive functions and addressing self-esteem issues.
- **Occupational Therapy:** To enhance graphomotor skills for academic tasks and daily activities.
- **Cognitive Training:** Techniques to boost working memory and attention, along with strategies to improve focus.
- **Speech-Language Therapy:** Working with a speech-language pathologist can help improve memory skills, particularly for verbal material.
- **Psychoeducation:** To empower Biggie with self-awareness and enable his to advocate for his needs in various settings.
- Additional support is recommended in areas like attentional function, processing speed, and cognitive efficiency. This can be achieved through occupational therapy, the use of organizational tools, and creating a distraction-free environment.
- Treatment options for ADHD should include behavioral techniques, stimulant medication consideration, environmental organization, and long-term perspective maintenance. Medical treatment discussion with a child and adolescent psychiatrist could be beneficial.
- Additional support is suggested in areas like auditory comprehension and complex figure copying. This can be accomplished through speech-language pathology and occupational therapy respectively. Use of visual aids and breaking down complex tasks into smaller steps can also be helpful.

Recommendations for School

- **Accommodated Testing:** Extended time accommodations are recommended due to relative weakness in processing speed and academic fluency.

- **Calculator Use:** Please consider allowing Biggie to utilize a calculator for class assignments and examinations as he progresses in the mathematics curriculum.
- Biggie should receive additional support in mathematics through:
  - Individual or small group tutoring.
  - Visual aids and hands-on activities.
  - Technology-based learning tools.
  - Real-life math scenarios practice.
  - Extra time for math-related tasks.
- Support within the educational setting, such as an individualized education plan (IEP) or 504 Plan, to address attentional/executive challenges. Academic accommodations should include extended time on tests, reduced copying from the board, or a note-taker to offset slower psychomotor speed and attentional challenges.
- **Adaptive Writing Tools:** Use of ergonomic pens or pencil grips for better control and fewer errors.
- **Graphomotor Exercises:** Drawing or tracing exercises for improved fine motor coordination.
- **Extra Time for Written Tasks:** Additional time for tasks requiring writing to compensate for slower graphomotor speed.
- **Technology Use:** Keyboard or voice-to-text software use to mitigate graphomotor weaknesses' effect on academic performance.
- Tutoring or teaching assistance is recommended for improving his sentence level writing fluency and overall academic fluency in reading, math, and writing.
- A supportive environment at home and school involving clear instructions, task breakdown into smaller steps, and praise for efforts and achievements.

Recommendations for Home

- **Mnemonic Devices:** Use of mnemonic strategies like acronyms or visual images for memory retention.
- **Organizational Strategies:** Note-taking, list-making, and visual schedules can provide external memory support.
- **Task Simplification:** Break down complex information into smaller, manageable parts for effective processing and remembering.
- **Repeated Exposure and Practice:** Repeated exposure to material and additional practice are beneficial due to below-average learning efficiency.
- **Set Reminders:** Use calendars, alarms, written notes, and lists for task reminders.
- **Mindfulness Training:** Technique to ignore distracting thoughts and concentrate on the task at hand, aiding in cognitive control.

Recommendations for Follow-Up Evaluation

- A follow-up assessment in 12-18 months is suggested to measure progress and assess the interventions' impact, unless urgent concerns arise. Continuous monitoring and reassessment are vital to adjust support as Biggie develops and his needs change.

It was a pleasure to work with Mr. Smalls. I am available to provide further information or clarification as needed.

Sincerely,

Thank you for considering this report in your evaluation of Mr. Smalls. I am available to provide further information or clarification as needed.

Respectfully submitted,

Joey W. Trampush, Ph.D.
Chief Neuropsychologist
Brainworkup Neuropsychology, LLC
Assistant Professor
Department of Psychiatry and the Behavioral Sciences
Keck School of Medicine of USC
CA License No. PSY29212

APPENDIX

Test Selection Procedures

Neuropsychological tests are performance-based, and cognitive performance is summarized above. Cultural considerations were made in selecting measures, interpreting results, and making diagnostic impressions and recommendations. Test scores are reported in comparison to same-age and sex/gender peers, with labels (e.g., Below Average, Average, Above Average; (Guilmette et al., 2020)), intended to be descriptive, not diagnostic. Standardized scores provide important context, but do not alone lead to accurate diagnosis or treatment recommendations.

Conversion of Test Scores

Range	Standard Score	*T* Score	Scaled Score	z-Score	Percentile (‰)
Exceptionally high score	130 +	70 +	16 +	2 +	98 +
Above average score	120 – 129	63 – 69	14 – 15	1.3 – 1.9	91 – 97
High average score	110 – 119	57 – 62	12 – 13	0.7 – 1.2	75 – 90
Average score	90 – 109	44 – 56	9 – 11	-0.7 – 0.6	25 – 74
Low average score	80 – 89	37 – 43	7 – 8	-1.3 – –0.6	9 – 24
Below average score	70 – 79	30 – 36	4 – 6	-2 – –1.4	2 – 8
Exceptionally low score	< 70	< 30	< 4	< –2	< 2

Guilmette, T. J., Sweet, J. J., Hebben, N., Koltai, D., Mahone, M. E., Spiegler, B. J., Stucky, K., Westerveld, M., & Conference Participants. (2020). American Academy of Clinical Neuropsychology consensus conference statement on uniform labeling of performance test scores. *The Clinical Neuropsychologist*, *34*(3), 437–453. https://doi.org/10.1080/13854046.2020.1722244