Farsi Action Foundation
REFERRAL FORM

Farsi Action Foundation
کانون همیاری پارسی زبانان

Please complete this form to refer a client to the Farsi Action Foundation. We support individuals from Farsi-speaking communities, as well as those who speak English or other languages. Our services are inclusive and available to people from all communities, offering advice, advocacy, and community support.

Referral Details

Referrer Name:

Position/Role:

Organisation:

Contact Email:

Contact Phone Number:

Date of Referral: / /

Client/Patient Details

Full Name:

Date of Birth: / /

Gender: ☐ Male ☐ Other ☐ Female ☐ Prefer not to say

Ethnicity:

Language(s) Spoken:

Contact Number:

Email (if applicable):

Current Address (if safe to share):

Reason for Referral / Presenting Issues

(Please provide a brief summary of the client's current situation and needs)

Consent and Confidentiality

☐ I confirm the client has given consent for this referral and for their personal data to be shared with the Farsi Action Foundation in line with GDPR and safeguarding policy.

Support Required from Farsi Action Foundation

☐ Benefits Advice

☐ Housing Support

☐ Mental Health Advocacy

☐ Translation/Interpretation

☐ Community Integration

☐ Other (please specify):

Referrer Signature:

Date: / /

Please return completed forms to:

info@farsiactionfoundation.com

+44 7810 647191 | +44 7545 679180

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FarsiActionFoundation