



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

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To: All North Carolina Clinicians
From: Emma Doran, MD, MPH, Medical Epidemiologist
Subject: 2026-2027 Respiratory Virus Season: **Testing Update for NC Clinicians** (4 pages)
Date: September 30, 2026

This memo provides information and guidance to NC clinicians regarding testing for respiratory viruses in North Carolina during the 2026-2027 respiratory season. As guidance may change during the season, updated information will be available at flu.nc.gov. Testing plays a critical role in detecting acute respiratory viral infections including infections with novel or variant influenza viruses that could have pandemic potential. Seasonal influenza, RSV, and COVID-19 may co-circulate throughout the respiratory season and co-infection with multiple viruses at the same time can occur.

Testing

Diagnostic tests available for detection of viruses in respiratory specimens include molecular assays (including rapid molecular assays, reverse transcription polymerase chain reaction (RT-PCR) and other nucleic acid amplification tests) and antigen detection tests (including rapid influenza diagnostic tests and immunofluorescence assays). Sensitivity and specificity can vary by the pathogen or test type, illness onset to specimen collection, the prevalence of viruses in patient population and other factors. Overall, molecular assays have a higher sensitivity and specificity than rapid antigen tests.

When available, multiplex assays for simultaneous detection of influenza, RSV and SARS-CoV-2 viruses should be used. It is possible for a patient to be infected with two or more viruses at the same time. Co-infections can impact the clinical management of acute respiratory illness. Testing for suspected pathogens should be considered particularly in hospitalized patients with severe respiratory disease. Additional guidance for clinicians when SARS-CoV-2 and influenza viruses are co-circulating can be found [here](#).

A negative rapid antigen test does NOT rule out infection and should not be used for treatment or infection control decisions during periods when influenza, RSV, and/or SARS-CoV-2 viruses are known to be circulating.

- RSV: Antigen testing is sensitive in children but less sensitive in adults. Health care providers should use highly sensitive rRT-PCR assays when testing older children and adults for RSV.
- COVID-19: A negative viral test result does not rule out infection and should be repeated following [CDC](#) and [FDA](#) recommendations.
- Influenza: Diagnostic tests available include molecular assays (including rapid molecular assays, reverse transcription polymerase chain reaction (RT-PCR) and other nucleic acid amplification tests); and antigen detection tests (including rapid influenza diagnostic tests and immunofluorescence assays). The [CDC](#) and [Infectious Diseases Society of America \(IDSA\)](#) recommends use of rapid influenza molecular assays over rapid influenza diagnostic tests

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(RIDTs) for detection of influenza viruses in respiratory specimens of outpatients. IDSA recommends use of RT-PCR or other molecular assays for detection of influenza viruses in respiratory specimens of hospitalized patients.

- NC Board of Pharmacy and NC Medical Board [protocols](#) allow pharmacists at retail locations to test and treat for influenza.
- Providers should be aware of circulating influenza and respiratory viruses. More information is available on the [NC Respiratory Virus Surveillance Dashboard](#).

Influenza and COVID-19 testing is available at the North Carolina State Laboratory of Public Health (SLPH). Respiratory season includes the peak season, shoulder season (acceleration/deceleration phase), and summer. The goal for this virologic surveillance is to have representative specimens throughout the calendar year. Guidance on respiratory pathogen submission to the SLPH can be found [here](#). Specimen submission guidance for the SLPH can be found [here](#). Specimens for surveillance should be submitted to SLPH for further testing and characterization in the following circumstances:

1. Specimens from confirmed influenza cases with severe illness and a poor prognosis.
2. Specimens from influenza associated deaths (adult and pediatric).
3. Patients who die with influenza-like illness but have no laboratory evidence of influenza, SARS-CoV-2, or other respiratory infection on a multiplex panel.
4. Patients who are critically ill with influenza-like illness but have no laboratory evidence of influenza, SARS-CoV-2, or other respiratory infection on a multiplex panel.
5. Patients with influenza-like illness, including conjunctivitis, with or without confirmatory testing for influenza, who have had contact with sick or dead livestock, poultry, or wild animals, contact with an animal known or presumed to have an HPAI infection, or consumption of raw milk or dairy products within the ten days before symptom onset.
6. Influenza positive specimens that are unable to be subtyped by tests designed to provide an influenza subtyping result.
7. A sample from patients with influenza-like illness seen at facilities participating in the outpatient Influenza-Like Illness Network (ILINet) or Influenza Hospitalization Surveillance Program (IHSP/RESP-NET). [Please consider joining ILINet if you have not done so.](#)

Testing at the SLPH should also be considered for patients in outbreaks in institutional settings or congregate living facilities and clusters of severe or unusual respiratory illness. Consult the [CDC Viral Respiratory Pathogens Toolkit for Nursing Homes](#) for further guidance and information on testing, prevention, preparedness, and controlling spread.

All specimens submitted to SLPH for influenza or SARS-CoV-2 testing will be tested for both influenza and SARS-CoV-2. Specific guidance regarding specimen collection and transport is available [here](#).

Human Novel or Variant Influenza

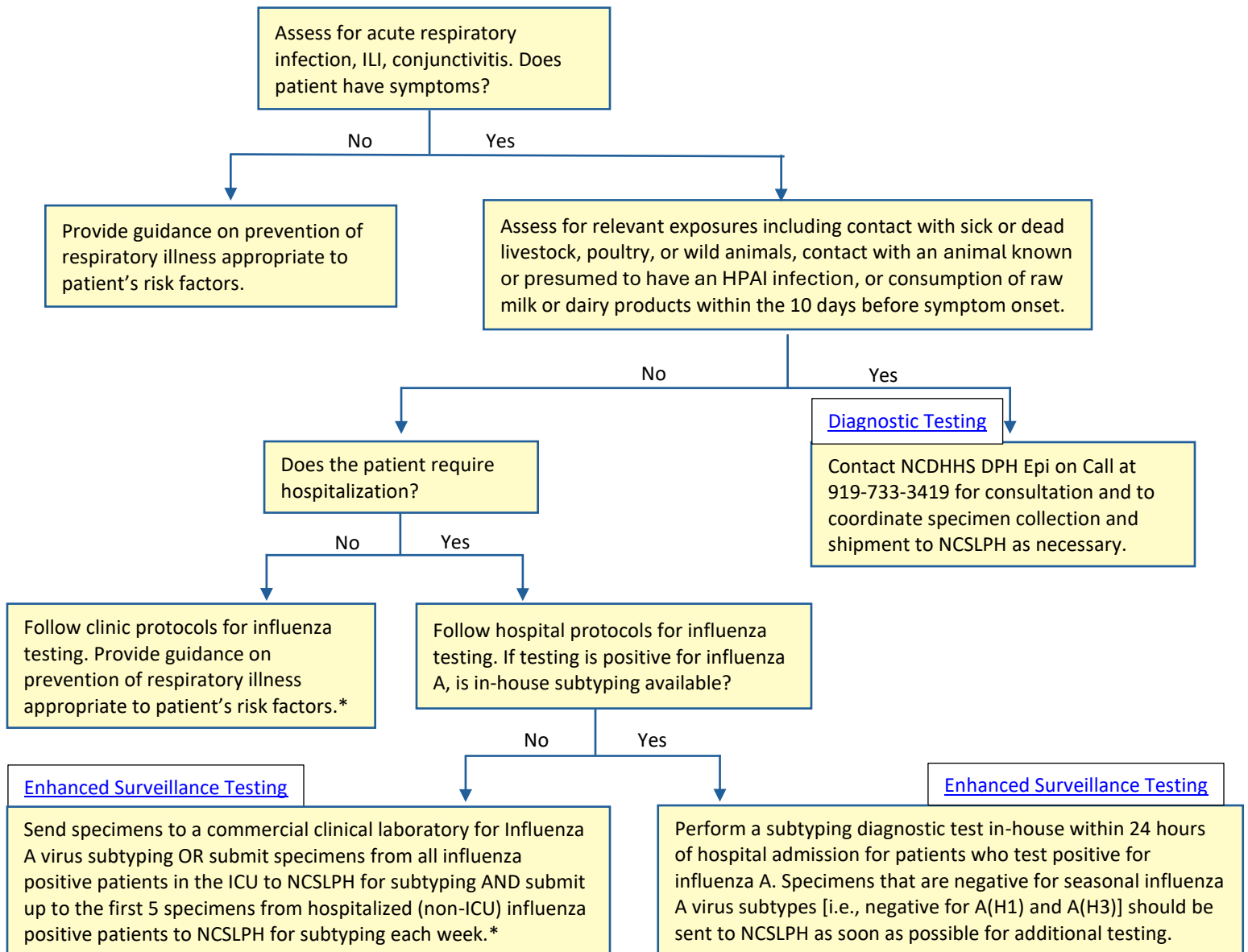
NCDHHS DPH requests your assistance with enhanced influenza surveillance and testing of individuals presenting with compatible illness and relevant exposure including contact with sick or dead livestock, poultry, or wild animals, contact with an animal known or presumed to have an HPAI infection, or consumption of raw milk or dairy products within the 10 days before symptom onset. **Please follow the algorithm on page 4** for detailed considerations when assessing influenza-like illness in patients. Additional information is available on the [NC DHHS Avian Flu Website](#) including the [Provider Memo page](#).

Access to COVID Testing

The federal program providing free at-home test kits to local health departments, community-based organizations, and other partners ended in June of 2025. Since the end of the federal Public Health Emergency, private insurance companies are no longer required to cover the full cost of at-home COVID-19 tests. Individuals should check with their insurance provider for their specific policy on at-home test reimbursement. Low or no-cost COVID-19 testing options may be available at [local public health departments](#), [local health centers](#), and some retail pharmacy locations, such as [CVS Health](#) or [Walgreens](#).

Clinicians should contact their [Local Health Departments](#), the Communicable Disease Branch epidemiologist on call available 24/7 at (919) 733-3419, or the respiratory team at RespiratorySurveillance@dhhs.nc.gov for questions about respiratory virus testing.

Influenza Testing Algorithm



*ILINet and RESP-Net sites should continue to follow existing guidance for submitting surveillance specimens.